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PSYCHOTIC REACTIONS IN THE LATE RECOVERY PERIOD FOLLOWING BRAIN INJURY

JOHN A. AITA, M.D., PH.D., AND RALPH M. REITAN, B.A.
Omaha, Nebraska

The recent war left many survivors with every possible type of intracranial destruction and alteration. The neurologic wards of army centers were filled with these patients during the war. We have marveled at what the human organism can endure and what recovery these men made(1). In this paper we shall review our experiences with chronic psychotic reactions appearing in the wake of brain injury.

From a series of 500 carefully observed men with craniocerebral injury, consecutively admitted to an army neurologic-neurosurgical center (in the zone of the interior), 4 cases of frank psychotic reactions appeared or persisted during the late recovery period. Over half these men had been wounded in action.

The distinction between reactions with intellectual impairment (deterioration) following brain injury and psychotic reactions is not always clear-cut. Both conditions may appear in the same patient. However, patients were not considered psychotic if the primary problem was simply a reduction of intellectual assets. Even in those demonstrating more serious intellectual impairment, the reactions were more like those of the mentally deficient than of the psychotic. A patient was considered psychotic when personality changes were serious and sweeping, disrupting all or nearly all forms of adaptation. His appreciation of reality was disturbed seriously and reactions were characterized by regression, delusional trends, or hallucinations. Such a patient was unable to care for his simple needs. He was a danger to himself and others, through neglect of his nutrition, suicidal tendencies, combative behavior, and a lack of insight into his illness and the treatment necessary.

I. PSYCHOTIC REACTIONS APPEARING AFTER INITIAL RECOVERY

In two cases the psychotic reactions first appeared in the late recovery period, after initial recovery and evacuation to a neurologic-neurosurgical center in the zone of the interior. The initial stupor, amnesia, and psychotic reactions (symptomatic psychoses or delirious reactions) seen in the acute stage following trauma and in the immediate recovery period had long since cleared.

CASE 1.—*Posttraumatic encephalopathy, moderately severe, due to penetrating shell fragments, manifested by surgical findings, right hemiparesis, and impairment of intellectual assets. Schizophrenic psychosis, paranoid type, acute; predisposition marked (schizoid personality); stress of combat experiences, wound and brain damage described above.*

Two weeks after admission, a 28-year-old private began to behave peculiarly. He was increasingly curt and outspoken to medical officers on rounds, resented strangers visiting the ward and declared he "was not a wax figure for inspection." His attitude toward ward personnel became cynical and humorously sarcastic, and he would not participate in the rehabilitation program. In the library he seemed to read and sleep a great deal. He had not written home since his return to the United States.

Several interviews at this time revealed a furtive, shallow, and detachedly intellectual manner. He subtly derided the army and the hospital. Advanced problems in chemistry and difficult puzzles preoccupied him. He spoke glibly of wanting to return to combat. The ward reminded him of "Alice in Wonderland, where they line you up like a lot of wax figures, pointing out spots, flaws, and defects on all those examined." Insight was lacking.

Three days after onset of this behavior, a craniotomy was performed for the insertion of a tantalum plate to cover a left temporal skull defect. Considerable extradural scar was removed. No evidence of active infection was found. His immediate postoperative behavior was unchanged.

Two weeks after the operation he was found outside the hospital grounds, barefoot and dressed only in pajamas, determinedly walking toward the city limits and insisting that he was going home. On return he talked blandly about going back to combat. Again he complained of maltreatment. His affect was flat, inappropriate, or facetious. He refused to eat and gave cryptic, vague reasons for this behavior. At no time was he disoriented; rather he seemed constantly alert, aloof, and cynically intellectual. Casually he explained how the defect in his skull now exposed his brain cells to the transgression of radio waves and other subtle cosmic energies. The next week he became increasingly

withdrawn, mute, and paranoid, then excited and uncooperative. Tube feeding, accepted passively, was necessary for several days.

About one month after the onset of these symptoms, he improved spontaneously. Three months after admission to the hospital (and 6 months after he was wounded) he was discharged to his home.

At no time did the cranial wound site reveal evidence of active infection, nor were lymph glands enlarged or temperature elevated. White blood count, differential polymorphonuclear study, spinal fluid tests, and sedimentation rate were normal.

Earlier Illness.—Two and a half months prior to this admission, the patient had been wounded in action by shell fragments which struck him in the left anterior temporo-parietal region. He recalled being struck, did not become unconscious for several minutes, and then was amnesic for 18 days. Field medical records indicated a small scalp wound, and initial surgery and x-rays revealed penetration of the dura and cerebral hemisphere almost to the pituitary gland by a small tract of foreign bodies. A right hemiplegia was also evident at that time. A transient aphasia followed initial surgery, but disappeared in a week; further recovery seemed uneventful.

On arrival at this hospital 2½ months after the wound, he complained of an occasional light headache at the site of the wound, excessive sleeping and eating, and slight clumsiness in his right leg. He minimized his disabilities and actually appeared very little disabled. Skull x-rays revealed a defect in the left anterior temporoparietal region which measured approximately 5 x 4 cm. and extended to the floor of the middle fossa. Neurologic examination revealed a slight paresis (with upper motor neurone signs) of the right leg and diminished joint sense in the right great toe. His facies were expressionless and blank. On the ward he was quiet and somewhat lethargic. EEG tracings revealed only a borderline abnormal record with no localization.

Psychological Tests.—The Wechsler-Bellevue Scale placed him in the superior adult intelligence range. His performance score was significantly lower than his verbal score; his use of "visualization" in the digit span test was interpreted as a schizoid method of attack. On the Binet vocabulary test he defined 43 out of 45 words correctly. The Rorschach test disclosed responses characteristic of both paranoid schizophrenia and organic cerebral deficit. Bizarre personal responses, position responses, confabulation, strong tendencies toward intellectual aggression, potential emotional violence, inadequate sense of reality, impaired judgment, and inferiority feelings were much in evidence.

His approach to the tests was decisive. He hardly paused to glance at instructions before beginning a test. He attempted to be cooperative but impressed the examiner with bizarre and eccentric behavior. He was indefinite about time and dates in his medical history and replied excessively with an automatic phrase, "It beats me."

Background.—The patient's mother and other relatives were intelligent informants.

His parents were Norwegian emigrants. As a child the patient never got along with his father, a strict disciplinarian, eager to push his son ahead. He had little understanding of his children and punished them often. The mother considered much of this treatment unwarranted and unjust. With adulthood, the patient's overt relationship to his father improved greatly.

The patient's mother frequently worked as a domestic to supplement the father's small earnings as a grocery clerk. She pictured herself in the rôle of a "buffer" between husband and children. Her son was much like her; both were "antisocial" and did not like people. In recent years she had quit working because of "a blood disorder," and read most of her spare time. She scorned people who were "fooled by religion."

The patient's only sibling was a sister 2 years younger than he, a tomboy who often had had to wear her brother's old clothing because of the family poverty. Described as a fine vocalist and pianist, she appeared manly but was warm and friendly. Some time before, her mother had discovered her in an "immoral sexual act" with an older woman to whom she was deeply attached. The mother was disturbed, the father "terribly indignant," finally ordering her out of the house. She then lived with a friend but was unable to work regularly and occasionally became very ill. The patient, though apparently aloof to his sister's problem, contributed a monthly allotment to her support.

The patient developed normally. His mother "made the children eat what they were supposed to." Toilet training was said to have been accomplished without difficulty. School was easy for him. He spent his spare time reading mathematics, physics, and chemistry and "studied all the time." He completed over 2 years in a local junior college, taking mostly science courses, in which he was outstanding. He left college because of lack of funds and the prospect of entering the army, but several years between then and his induction in 1941 remain unaccounted for. Both he and his family were vague about this period. His father repeatedly nagged at him to get a job and he did work at several part-time jobs.

The patient stated that he paid no attention to girls because he preferred to putter around with chemicals and mathematics for amusement. His only heterosexual experience, in his late teens, left him uninterested. According to his mother, he had "utter contempt for women in general." Homosexual experiences were denied.

This patient was always known to be asocial, shy, evasive, and cryptic. Often when visitors would come to the home he would walk to his room and slam the door. He would never eat in the presence of the family or strangers. Although described as a fine violinist who enjoyed playing, he would abruptly stop playing and go directly to his room if anyone came in. He was also interested in art and painted statues of nude women with unusual intensity. In his ambition to become a research chemist, he spent most of his money on books,

magazines, and files dealing with research and chemistry.

At the age of 25, in 1941, he was inducted into the army, and soon afterward was sent to officers' candidate school, where he failed. The patient felt that this failure was relatively unimportant to him because success depended wholly upon how well one got along with people, and he had never liked people. Always penurious, he once wrote in a letter to his parents that he had spent only 25 cents in 3 months. He wrote home infrequently.

After advancement to squad leader in an infantry division he was sent overseas in June, 1943. He was thrice demoted from ratings because of his "very independent attitude." He was wounded after 3 months' combat as a B.A.R. rifleman in the Southwest Pacific and Philippine Islands. He recalled that once he violently attacked a soldier who had taken his bunk. He choked him and attacked him with a knife intending to "slice him in two." The man went to the ship hospital with severe lacerations.

Follow-Up.—The patient and his mother were interviewed by a Red Cross social service worker 9 months after his discharge. He still resented his confinement in the "nut ward" of the hospital and his medical discharge, and disclosed no insight. His mother had found him "very trying and difficult to get along with for months. He was aloof, moody and irritable; he refused to see a doctor. He felt thwarted on every hand. He wanted to take up his studies again, but the university advised waiting. Gradually he became less tense, began to read again and display some interest in music, but he would stop abruptly when he observed I was listening. Finally, he made little overtures at conversation and gradually grew light-hearted and gay. It was surprising to hear him laugh again."

He had worked 10 weeks in a small manufacturing plant, quitting because the work left him too tired to study. He then devoted himself to more intensive home study, especially "research" in physics, chemistry, and mathematics. He showed the social service worker a copy of an advanced technical journal which he read regularly, frequently writing to the editor about mistakes in the articles. He still contentedly referred to himself as "antisocial," and spoke of returning to the university, but not of getting a job. He continued to receive 60% disability compensation from the Veterans Administration although insisting he did not feel even 2% disabled.

CASE 2.—*Posttraumatic encephalopathy, moderately severe, due to closed head injury and cerebral contusion, manifested by initial bloody cerebrospinal fluid; history of one convulsive seizure, left hemiparesis, and impairment of intellectual assets; pneumoencephalogram normal. Schizophrenic psychosis, mixed type, acute, recurrent; predisposition suggestive; major stress of father's death, loss of home by fire, combat experiences, wound and brain damage described above.*

One week after admission to the neurologic service, a 25-year-old private became withdrawn and mute. A few days later he became uncooperative and excited and had to be transferred to a closed ward. Mental status notes at this time recorded the following interview:

Patient was a small, slender man, dishevelled, with dark complexion and a sensitive, childish face. His expression was doleful and serious. He casually told the examiner that he had one more wish, that his blood would turn to type O. Meantime, he toyed with a bit of cotton, and obviously had just had a blood specimen taken. He stated abruptly, "The peroxide test will not lie either. Is there anything else now, Captain?"

Question: What did they do to you? *Answer:* To prove identity, blood type or watermelon. Blood type with O at first. That's the truth, the whole truth, and nothing but. (He stood at attention by the bed side, holding up his right hand as if to take oath). Dramatically he then announced, "Captain Studebaker, you would make a wonderful aid corps man."

Asked to sit down, he slowly did so, but continued to speak in a slow, deliberate, serious manner, at times dramatic.

Q: Why are you in this hospital? *A:* At the present time, sir, I'm in the Mayo General Hospital at Galesburg, Illinois.

Q: Why are you here? *A:* Mental disorders.

Q: What do you mean by that? *A:* Imaginary things, like why was father's whiskers gray before his hair. His answer was a secret. I wore a cotton mustache at one time, but that boy was not gray; he was white.

He now appeared slowed, sad, tired, but nevertheless friendly. He smiled slowly, with many irrelevant responses as "Luckystrike and lucky struck do not lie." Later he inquired, "Why is a captain associated with chaplain? I answered, Studebaker." Asked who Captain Studebaker was, he explained that Captain Studebaker was his first commander of Company B. He then gave an infantry regiment and an A.P.O. number. Next he praised this company commander, calling him, "A champion," and in the same breath, he added, "Medical pills are swallowable, nicotinic pills are not."

When asked about worries or other preoccupations, he replied, "Yes, I have a worry. It's a way of discarding red, white, and blue cigarettes."

Q: Why would you want to do that? *A:* To end the habit of taking pills.

As the interview proceeded, he spoke slowly and hesitantly, in a stilted, polite way. At times, however, he spoke with great emotion. The nurses had reported paranoid trends, but in this interview they could not be elicited. When asked how people were treating him he stated formally, "Fine, sir." He said that the static from radio annoyed him, but would not elucidate further. He talked of "imaginable people" asking him personal questions.

He was alert, active, and appeared in no way clouded or disoriented. He knew the length of his present hospital stay and his various transfers during evacuation from the European Theatre. He knew his home town and address, and could give general directions on how to get there.

During the interview, he displayed mood variations from grandiosity to mild depression. When asked about his inner feelings, he readily admitted feeling "mentally depressed." He had some evanescent insight, indicated by such statements as, "My mind plays funny tricks but I'm double checking that. I almost sweated blood, but the flying wreck landed without an accident. I'll sign that statement." (He noted that the examiner was taking down verbatim statements.) "The reparable wreck landed without accident. That would be the medical way of saying it. Don't ask me who's my favorite cartoonist. That would be the most favorable answer." By this time he was again standing by the side of his bed at attention, speaking in serious, dramatic tones.

Later he asked a social service worker to write a letter to his mother, but admonished her to censor it before sending it. His letter was as disconnected as his conversation. He asked for various changes and objected to telling his family the date of his arrival or the name of the hospital, because it was military information: "We are still fighting the Japs, even if we are not doing a good job of it." Then he became tearful, perspired profusely, and cowered on the bed at mention of his company.

The Rorschach test at this time disclosed a predominance of schizophrenic responses characterized by bizarre associations, confabulation, contamination, position responses, edging, extremely poor emotional control, an inadequate sense of reality, and impaired judgment. Agnosia—apraxia tests demonstrated no disability.

He continued excited, autistically distracted, and overproductive, frequently ignoring questions and rambling incoherently. He saluted everyone in a grandiose fashion. He later admitted hearing voices, particularly his mother's, whereupon his own voice would change to a high pitched, feminine tone. He frequently referred to homosexuality. It was difficult to test his orientation and memory because of distractibility, but no certain defects could be demonstrated. He appeared alert at all times. Complete examinations and blood studies indicated no infectious or toxic causes for a psychosis.

At the end of 2 months he was able to return to an open ward, where he continued to improve. He took part in ward activities and reacted well to superficial psychotherapy. He expressed gratitude for treatment and recognized that he had a mental illness but continued seclusive. He claimed that the news of his father's death while he was overseas caused him to brood.

Seven months after he was wounded, a Bellevue-Wechsler Scale revealed a mental age of 13 years, with significantly better verbal than performance scores. The psychologist reported, "The patient was cooperative and made an effort to do well. It was felt that the test results are representative of his present functioning level of intelligence. There seemed to be two trends; strong indications of organic brain damage and schizophrenic traits. The most conspicuous signs of brain damage were in the consistently low scores on the visual-motor coordination tests, with the digit symbol test the lowest of all subtest scores. There were also poor scores in visual organization, and impairment of attention and concentration. The patient demonstrated much difficulty in all tests requiring analysis and synthesis, performing poorly, realizing that his production was not correct, yet being unable to achieve a satisfactory product. The scatter pattern conformed to that found in persons with cerebral damage. Schizoid traits appeared in an item analysis of the results. Some easy items were missed even though more difficult items were performed correctly. Qualitative analysis revealed erratic performance in verbal concept formation demonstrated by bizarre answers replete with personal references, and superficial responses alternating with replies of good quality."

As he improved, he verbalized other preoccupations, principally how depressed he had been at times while overseas. He worried over his mother's fears, and felt that he had persecuted her unjustly by volunteering for an airborne division. At times he felt so depressed he considered suicide.

Eight months after he was wounded, he was discharged to his own custody to return home.

Present Illness.—Two months prior to entry this patient was wounded in action by explosion of a land mine. He incurred a severe laceration of the right frontal and parietal scalp without fracture or defect in the skull. He had no recollection of the incident and was amnesic for one week following it.

Initial examination after the injury demonstrated a left hemiplegia. Seven days after the injury, a spinal fluid examination revealed bloody spinal fluid. Further examination disclosed a left facial paresis and an ill-defined (poorly documented) extraocular palsy. One month after injury, he still appeared mentally slowed and residual left hemiparesis lingered. At this time he had one convulsive seizure. Evacuation was otherwise uneventful and no abnormal mental reactions were noted. Upon arrival at this hospital, he complained only of awkwardness of his left arm and leg.

Initial physical examination revealed a large, well-healed scar in the right frontoparietal scalp. Paresis of both left extremities was readily elicited; spinal fluid pressure, cell count, and protein content were normal. X-ray of the head was negative, and a pneumoencephalogram revealed no significant findings. A minimal compression type fracture of the 6th thoracic vertebral body was present.

Social service contact with the patient's family obtained the following information pertinent to his present illness. Some 4 months prior to the head wound, the patient's letters from overseas indicated despair that he was losing his mind and "thinking in circles." A letter to a girl told her to get another boy friend, that his "brain was dead." He also wrote a letter to his father, who had then been dead a year.

Background.—Parents were born in Poland. Maternal grandfather was once hospitalized in a state hospital. The patient was the second of 4 siblings; both parents had other children by first marriages. Nothing unusual was elicited concerning the patient's birth and early development. The family

lived on a small farm. Patient finished elementary parochial school at 14, with good grades. He always read avidly. One sister reported that he had read all of the Encyclopedia Britannica before he was 17. Regarded as something of a "mechanical genius" by the family, he spent most of his time alone hunting and fishing, reading and building or repairing things around the farm. At the age of 12, with his 14-year-old brother, he designed and built a hangar-type garage large enough to house much farm equipment, including a tractor. The father furnished money for materials and tools. Such work saved a great deal of money. The patient also installed complete electrification about the house and farm. He and his older brother diligently assisted the father to operate the farm.

He did not smoke until he entered the Army. He refused to learn to dance and went out with girls only rarely, preferring the company of his own family. He was always considered clean, unusually truthful and obedient, serious and untalkative. The neighbors admired him. He attended Catholic church regularly.

While the patient was overseas his father died of cardiac disease at the age of 55 years. The farm home burned soon afterwards and all the household equipment was lost. The patient, informed of these events, revealed in his letters that he was quite disturbed. This was about 9 months before the onset of the psychosis.

One year after his induction, at the age of 23, he was sent to the European Theatre. He was in combat as a paratrooper in Normandy, Holland, and Belgium. His mother felt that his adjustment to army experiences had been difficult. He was always a small individual who put forth a maximum physical effort to carry his share of the work.

Follow-Up.—On return home, he helped his mother about the house but did not find remunerative employment. A month after discharge he again showed abnormal behavior. Following an airplane ride, he became excited and talked a great deal. He visited his father's grave but said his father was not dead. He slept little, would get up in the middle of the night, dress and leave the house. One night his mother tried to stop him and he became so acutely excited that she called for police assistance. From jail he was admitted to the nearest Veterans Hospital, where he was described as "relevant, coherent, partially oriented, immature, and smiling inappropriately." He admitted auditory hallucinations but denied ideas of reference or suicide, saying he was hospitalized now because he was too kind-hearted, and children followed him around asking for apples. Someone was reading his mind and controlling it to a certain extent, and other patients could hypnotize him. Sometimes he thought he was "nuts," he said. After transfer to the continued treatment ward he appeared superficial, maneristic, smiled inappropriately, and spoke of being hypnotized. He complained that electricity passed through his body when he was near a radio. Three months later he was improved moderately and was discharged to his mother against medical advice.

II. Initial Chronic Psychotic Reactions Persisting Into the Late Recovery Period

In contrast to these cases were 2 in which the initial psychosis due to brain injury did not clear up but was prolonged for several months. Both cases showed a prolonged confabulatory-amnesic type of psychosis which cleared gradually, leaving evidence of considerable intellectual deficit. Both were associated with closed head injuries, without fracture.

Case 3.—*Posttraumatic encephalopathy, severe, due to closed craniocerebral injury and cerebral contusion, manifested by paresis of left leg, equivocal plantar signs, sensory alteration on left side, prolonged confabulatory-amnesic psychosis, impairment of intellectual assets and pneumoencephalographic evidence of marked hydrocephalus ex vacuo.*

Upon admission this 35-year-old private was noted to be unusually dull and confused, with bland, perplexed facial expressions. He was hesitant and apparently unable to act spontaneously; however, he seemed to cooperate in a willing although child-like way. In a manner naive and mildly euphoric, he disclaimed any illness and felt that everything was all right. At times he smiled in a friendly, appropriate manner. His understanding of his hospitalization was nil. He seemed vaguely aware that the interviewer was a Medical Corps Officer, but when asked if the medical officer could be a legal advisor, he said that he thought so, pointing out that we had asked him questions about his previous employment, and so on. He could not resolve this disparity nor did he even seem aware that one existed.

Abundant gaps in memory and current information were evident. He was unknowingly repetitious and at irrelevant places introduced a specific story, *viz.*, that he met his brother in Germany. He attributed his brother's discharge to length of service, and when further questioning disclosed less than 2 years' service, he admitted that this was too short, but continued to assert, "It's probably the length of service." His affective display was considered appropriate and without the detachment or withdrawal of a schizophrenic reaction.

While in the hospital he would frequently call home, sometimes making 2 or 3 long distance calls a day. He seemed lonesome and at times anxious. He always forgot that he had made previous long distance calls.

Present Illness.—Three months prior to entry the patient was allegedly struck on the back of his head by a baseball bat. He immediately became unconscious and remained so for some days, during which time trephine holes were placed in his skull. However, these initial records disclosed no surgical or neurologic findings or spinal fluid examinations. On regaining consciousness he was obviously clouded and lethargic. His stream of

thought was irrelevant and confabulatory. He was grossly disoriented in all spheres. He became emaciated and was at times somnolent. He spent much time fumbling with the sheets or tying and untying his pajama cord. He was incontinent of urine and feces. He complained peculiarly of "gas pains" in his head.

During the course of his evacuation he could give no coherent story except occasionally to state that he believed he was hit on the head by a baseball bat. He remained disoriented and demonstrated prolonged anterograde as well as retrograde amnesia.

Two months after the injury he was still described as emaciated and confabulatory, but usually cooperative. He continued frequently incontinent of both feces and urine. He participated superficially in occupational therapy, gymnasium and ward activities and at times seemed fully aware of being hospitalized.

At neurologic examination 3 months after injury he appeared older than stated age. He was thin, placid, dull and his facies were washed out. There was a minimal paresis of the left leg. Plantar responses were equivocal. A subjective though persistent sinistral distortion of superficial sensation was elicited.

EEG tracing 3 months after injury disclosed only a borderline abnormal record with no focus; the right temporal voltage was slightly greater than the left. Lumbar puncture and spinal fluid examination were negative after arrival at this hospital. X-rays of skull revealed only 2 round defects about one centimeter in diameter in the central portion of each parietal bone. Pneumoencephalogram revealed a marked generalized cortical atrophy and dilatation of the ventricular system.

The Rorschach test indicated that the patient's personality structure was seriously disturbed. The most striking finding was his poor intellectual control, deviation from reality, inadequate judgment, and perseverative tendencies. In 7 of his 16 responses he reported that he was reminded of animals that had been skinned. In instances where the ink blot looked little like an animal skin, he mentioned that the skinning had been poorly done. In one instance he believed that one of a pair of animals was very happy and the other very sad, even though these animals were represented by nearly identical figures on opposite sides of the card. He was unable to point out the specific details of the figures which gave him the impression of happiness in one case and sadness in the other. The record suggested that the subject was dependent upon social contacts and experiences. His emotional control, however, was at a definitely immature level.

Comprehensive grammar school tests indicated that his reading vocabulary was at a 6th grade level and arithmetic at 4th grade. A Wechsler Bellevue Scale revealed a verbal score of 83, a performance score of 66, a full scale score of 73, and a mental age of 11 years and 6 months. All measures except those dependent upon old learning, form recognition, and immediate memory span fell well below the expected levels. The scores indicated that the subject was capable of little abstraction, synthesis, anticipation, and ability for new learning. Bizarre answers were numerous; *e. g.*, to the question, "In what way are a radio and a newspaper alike?," he stated, "They are both unseen. You can't see radio waves or thin paper." Asked to repeat 719 backwards, he said, "405, which is just half." He located Brazil in Argentina and successfully completed only one picture arrangement; for disorderly arrangements he gave bizarre explanations, with evidence of contamination and circumstantiality in his thinking. However, he was cooperative and appeared perfectly at ease throughout the tests.

Course in the Hospital.—The patient soon learned to find his way around the hospital. Insight was entirely lacking. He constantly stated that he felt perfectly well and saw no reason for his stay. He had a marked lack of drive and initiative, with considerable submissiveness to other patients, and would run all their errands. Occasionally, when pressed too much he flared up violently but soon calmed down again. Once he received $159.00 in back pay and within 15 minutes lost $50.00 in a card game. One of the players, realizing the unfairness, saw to it that the patient got his money back and quit playing.

In the company of his wife he was allowed 2 furloughs. His wife discussed his behavior at home as follows: He appeared helpless and expected a lot, showed little initiative and wanted to be waited on. In general he was careless. He shaved himself poorly. One day he decided to shovel snow, but the result was childlike. He said that when he got out of the Army he wanted to become a policeman. Although he soon found his way about in the neighborhood zone, he was otherwise forgetful and easily mixed up. For instance, he would telephone the same people several times a day, forgetting the previous calls. He expressed no particular worries or trends and revealed little reaction to his wife's feelings. At home his temper was easily controlled and he was not suspicious or paranoid. He ate excessively but had good control of bladder and bowels. Occasionally he would arise at 4:00 a. m., saying in a businesslike manner that he was going somewhere, but was always easily persuaded to remain home.

It was repeatedly emphasized that the patient's home situation was bad. His wife got along poorly with his dominating family, and her sickly mother and sister lived in the patient's home. These factors hindered his adjustment.

Disposition.—Because of severe deterioration and persistence of minor confabulatory-amnesic symptoms and the incompatible home situation, the patient was discharged to the Veterans' hospital 3 months after admission.

Background.—The patient was one of 10 children of foreign-born parents. He had quit school in the 8th grade and was said to have done average work with no failures. He had held many jobs of unskilled labor. During 5 years at a poultry concern he had advanced to receiving clerk, when he was

inducted. He had married 3 years before, at the age of 30, and had no children. Previous personality was not unusual, except that his wife described him as extremely moody at times and difficult to understand; or he could be "the life of the party," but his wife never knew when to expect this mood. She felt he had always been shy. He had not been a favorite in his dominating family, and there had been some hard feelings. Clearly, his wife likewise did not get along well with his folks.

Follow-Up.—In a follow-up report 2 years after the patient's injury, his wife stated they separated because of the predatory domination of his family. In the months after his discharge from the army his moods were changeable; when she saw him alone he appeared able to think well, but the appearance of his family disturbed him "dreadfully." He constantly broke minor rules of the Veterans' hospital and chafed and fretted considerably. His wife and parents competed to see who would visit him or take him out. Recently, 22 months after injury, the patient was released from the Veterans' hospital and returned to his previous employment, although now at unskilled labor. He "does as he is told and then folds his arms and stares into space until he is told what else to do. He is always prompt for work but has no initiative and does not mix with his fellow employees. He smokes incessantly and would drink, too, but I believe he is afraid of his family."

CASE 4.—*Posttraumatic encephalopathy, severe, due to closed craniocerebral injury and cerebral contusion, manifested by initially bloody spinal fluid, absent left abdominal reflexes, equivocal left Babinski sign, prolonged confabulatory-amnesic psychosis, impairment of intellectual assets and pneumoencephalographic evidence of hydrocephalus ex vacuo.*

A consultation was requested in the case of a 39-year-old captain who had incurred a severe comminuted fracture of the right femur and patella 3 months previously. Although frequent mental changes were noted, the patient cooperated fairly well and orthopedic management was so urgent that these mental changes were not given much attention.

Initial examination revealed a bedridden patient with his right leg in traction. He was disoriented in all spheres, described both visual and auditory hallucinations, requested that his wife push the cats off the bed, and talked about army responsibilities to people not in the room. He was in restraint. He gave his age as 23 years, would shake hands with the examiner and then burst into tears; once he broke into sudden, inappropriate laughter.

Toxic and infectious causes were ruled out. The patient's state of nutrition was good and he was not dehydrated. His spinal fluid examination revealed normal pressure, cell count, and protein. The left abdominal reflexes were absent and the left Babinski sign was equivocal. His facial expression was washed out and childlike. He confabulated at length concerning his athletic prowess, the importance of members of his family, and a bequest of several million dollars from an uncle.

Present Illness.—Three months previously the patient had been injured when the car he was driving collided with an interurban train. He received multiple lacerations, one over his right eye, and a comminuted fracture of his right femur and right patella. Immediate examination revealed a positive left Babinski sign and bloody spinal fluid. He was unconscious about a week.

Course.—The patient's psychotic reaction began to clear up about 4 months after injury, when he was able to get around on walking calipers. Some confabulation persisted, and marked personality changes and intellectual deficit were much in evidence. Six months after the injury, prolonged amnesia was still evident: he could recall to within a few days before the accident but had no recollection of the accident. First islands of memory following the accident did not appear until 4 months afterward.

EEG tracings 3 months after injury revealed a general distribution of 8- to 10-per-second waves mixed with low voltage fast activity. Right frontal and temporal lead areas showed baseline sway and were of higher voltage than left. Nine months after injury the tracing revealed a generalized distribution of 8- to 10-per-second waves mixed with low voltage and some 15- to 20-per-second activity. Some single and scattered 6- to 7-per-second waves recurred in all leads. The left temporal area revealed higher voltage than the right.

Eight months after injury the patient's Rorschach record gave strong indications of brain injury. The patient seemed to recognize his intellectual disability to some extent. He gave evidence in his responses of an attempt to exercise rational censorship of his associations, but nevertheless definite deviations from reality were apparent. The subject's ability to analyze, organize, and synthesize the relatively unstructuralized stimuli presented by the ink blots was at a low level. His fantasy activity and potentiality for creative effort were definitely limited. The record also gave evidence of an immature emotional adjustment, implying that his control in emotional situations would be inadequate. Indications of anxiety and depression were present as important features.

Eight months after injury the Weschler-Bellevue Scale indicated a verbal score of 37, a performance score of 44, and a full scale score of 81, equivalent to a mental age of 12 years and 4 months, or an IQ of 98. Deficiences noted were localized in his ability to learn new material, to manipulate abstract concepts, to consider simultaneously or in rapid alternation more than one aspect of a problem or situation, and to initiate modifications or a complete change in his approach when proper solution of the problem demanded it. During the test administration he made numerous irrelevant comments related to his physical condition and expressed feelings of anxiety, insecurity, and inferiority. His cooperation was good.

An agnosia-apraxia battery of tests administered 6 months after injury revealed no defects of this type.

Grammar school achievement tests, including

reading comprehension and vocabulary, arithmetic, English, and spelling revealed performance not above the 4th and 5th grade level.

The Bender Gestalt test also showed disorganized manner of approach and inability to work with 2 concepts or 2 figures at once. The spatial relationship of all drawings to one another and the specific procedure used in some indicated a picture of organic involvement overlaid by deep concern and anxiety; the size of certain ones indicated anxiety, insecurity, and self-concern.

Pneumoencephalography performed 6 months after injury revealed an excellent example of moderately severe hydrocephalus ex vacuo, more advanced on the left than right side.

Course in Hospital.—As the patient continued to recover slowly, memory defects for his past life gradually disappeared. Friends who had known him previously described his personality changes (6 months after injury) as follows: "The difference in him before the accident and now is the difference between day and night. He seems like a fellow under the influence of some sedative drug. He was always a jolly fellow, the life of the party, a hale fellow well met, and he was also decisive and quick and definite. He could make up his mind in a flash and act on it. He was well liked by his enlisted men and was considerate of them, but he would come around to his outfit, size up the situation, snap out an order, and that was the end of it. Even if these snap decisions were not so good, they would not bother him. He was just the kind to laugh it off lightly and that was all. He was always self-assured. At home he was something of a tyrant; not mean or unkind, but dictatorial. He liked to show that he was the boss. If something was suggested that he thought questioned his authority he would almost invariably do the opposite.

"At present, he is the same, pleasant person as before, but he is not the man he used to be. Now he is unsure and uncertain. He has to let his wife take care of him and he does whatever she says. He has lost most of his old businesslike secretiveness. He now speaks too readily about his personal problems and at times seems to be exaggerating. At times he acts expansively as he might under the influence of liquor. So preoccupied with his condition, he has an almost constant look of worry and insecurity."

Eight months after injury the patient came to an interview wearing a leg brace. He waited to be asked, then sat down hesitantly, was unusually polite in a military manner. His expression was pathetic and doleful. His numerous vague generalizations displayed lack of assurance and inability to face his future capacity: "I'm worrying about my head. My mind isn't what it used to be. I know I can't hold any responsible positions like I held before. I was always known to have a brilliant mind. I don't want to do anything wrong and I don't want to offend or hurt anyone. I don't want to be wrong about anything. The army brought me up that way." Yet he was unable to define any specific defect of mentation except a difficulty in verbalizing spontaneous thoughts and some sluggishness in attempting to think quickly. He worried about misstatements or offenses which were purely projected specters. Obviously he clung to his invalid, noneffective status, without specific, delineated complaints.

He was now constantly hounding for sick leave. He continued to be anxious, passive, and dependent, clinging all too easily to his invalidism, despite moderately good insight into his intellectual losses. His wife reported that he continued to worry about the accident and whether he would receive retirement pay. There were no paranoid trends, but a definite loss of old interest and ambition continued. He was slow and phlegmatic and spent most of his time reading the newspaper or listening to radio mysteries. This lack of interest particularly bothered his wife, whose intellectual and emotional immaturity was no present asset.

The patient was careful if not penurious about his money and would sign no documents without consulting a trusted friend.

Background.—His early life had been insecure and unhappy. When the patient was 6 his father, said to have been "subject to epileptic attacks," was killed in a robbery. The mother remarried soon after; despite several siblings and stepsiblings the patient was a "lonely child," openly resented by his stepfather. When he was about 12, his mother died and he went to live with an aunt and uncle, but by 16 he had drifted away from most of his family and no longer retained close attachment to them.

The patient completed the 6th grade with no outstanding difficulties or interests. He then worked as a mechanic in oil fields until he was 16, when he joined the regular army and advanced to the rank of sergeant.

The patient at 19 married a girl who died 2 years later in childbirth. At 26 he remarried but was divorced a year later. His present wife had also been married twice before, and was described as jealous, fretful, and demanding, during their 2 years of marriage.

He had liked army life and had many friends all over the world in the posts at which he had been stationed. He was always strong-headed and had his own ideas about things. Although quite frank with people, he was usually cheerful, enjoyed fun, and was held in high regard by fellow officers. His friendships were wholehearted, and he avoided individuals he disliked. He was noted for great perseverance, strong physical constitution, and great initiative and resourcefulness. His private life was quiet and he was reticent about his personal affairs.

Disposition.—The patient was retired from the army 10 months after injury, and discharged to members of his family.

Follow-up.—Two years after his injury the patient reported he had divorced his wife. For the most part he conducted his affairs independently, with minimal, informal supervision. He was working again in the oil fields, and the trend of his letter was euphoric and carefree.

Discussion

Many authorities(2) have frowned rightfully on the oversimplification of these matters and the ease with which the diagnosis of *posttraumatic* psychosis is made. Such diagnoses often are made on simple *post hoc* supposition or without careful psychiatric evaluation.

To imply, however, that only 4 men out of 500 with craniocerebral injury will become psychotic is misleading. Actually we saw these men while they were still protected by the army hospital for many months. We may expect other personalities to break as later civil adjustments become trying. Situational problems may drive some into temporary "catastrophic" (depressive, panic, furor, or paranoid) reactions(3). Epileptiform discharges may likewise produce episodic behavioral changes, gross or subtle. Individuals with brain injury likewise may react excessively to drug intoxication, infection, or avitaminosis with transient psychotic outbursts.

Summary

In the observation of 500 cases of craniocerebral injury evacuated to an army neurologic center several months after injury, 4 cases of psychosis appeared. These are described in detail.

Two cases may be classified as schizophrenic reactions in which brain injury played a secondary rôle. At the most, the experience of trauma, brain damage, and resulting state of deficit served as an aggravating factor. Follow-up study revealed neither patient able to pursue steady or gainful occupation.

Two cases may be classified as prolonged, primary traumatic psychotic reactions (confabulatory-amnesic type) in which brain damage appeared to be the outstanding causative factor. Follow-up study revealed that both patients had been able to return to simple, but steady and gainful, occupational adjustments despite some intellectual impairment.

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WAR CRIMES

Their Social-Psychological Aspects [1]

LEO ALEXANDER, M. D.[2]

War crimes are crimes committed with group approval. In this way war crimes are similar to gang crimes, and different from crimes committed by single individuals in ordinary society. The main approving and instigating group in Germany during the Nazi régime was the SS, which was the most important political organization in Nazi Germany.

SS stands for *Schutz-Staffel,* which, translated, means "protective squadron." No totalitarian state can function without an SS-like organization. It is therefore important for us to know all we can about the SS, to understand its motivation and how it worked, what its strength was and what its weaknesses were; and it is the duty of sociologists, psychologists, and psychiatrists to study these facts and to make them generally understood.

The SS was a criminal organization not only because its members actually committed crimes, but also because the essential mode of its thinking and its group behavior were those of all criminal organizations. If a member did anything which put his loyalty to the organization in a questionable light, he was either liquidated—killed—or he had to undertake a criminal act which definitely and irrevocably tied him to the organization. According to the age-old custom of criminal gangs, this act had to include murder. In the SS this process of reinforcement of group cohesion was called *Blutkitt* (blood cement), a term which Hitler himself is said to have obtained from a book on Genghis Khan in which this technique of obtaining group cohesion was emphasized.

Examples of "blood cement" among prominent SS men were numerous. One striking example is that of Dr. Karl Gebhardt, who was a well-known specialist in bone and joint surgery, professor of surgery at the University of Berlin, and surgeon-in-chief of the renowned Hohenlychen Hospital. He held general's rank in the SS. He was suspected of having contributed to the death of Heydrich by failing to treat his wound infection with sulfonamides. This omission made him politically suspect and he was then expected to commit a crime which would dispel the suspicions against him and tie him more tightly into the SS criminal organization. The blood cement used in this case was a series of criminal experiments carried out on young girls captured from the Polish resistance movement, in whom he produced wounds complicated by tissue destruction and subsequently infected with gas gangrene bacilli. When a number of these victims died in spite of sulfonamide treatment, he thus proved that Heydrich's death was "fate-determined" (a favorite SS phrase), and that he was not guilty of causing it. Gebhart went one step further and involved the entire German medical profession in "SS blood cement" by presenting his report before a national medical meeting where no objections were raised by the members.

Viktor Hermann Brack, an official in Hitler's chancellory office, after having been suspiciously anxious to release various people from concentration camps and insubordinately critical of the "winter catastrophe" in Russia, was entrusted by Himmler with the working-out of plans for mass sterilization and mass extermination of Jews and conquered peoples.

Dr. Sigmund Rascher did not become the notorious vivisectionist of Dachau Concentration Camp and the willing tool of Himmler's research interests until after he had been forbidden to use the facilities of the Pathological Institute of the University of

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[1] Read before the Massachusetts Psychiatric Society, January 29, 1948.

[2] Consultant to the Secretary of War of the United States, on duty with the Office of the Chief of Counsel for War Crimes in Nürnberg, U. S. Zone of Germany, 1946-1947; Lieutenant Colonel, ORC, MC, USA; Associate Director of Research, Boston State Hospital; Instructor in Psychiatry, Tufts College Medical School, Boston, Massachusetts.

Munich because he was suspected of having Communist sympathies. Then he was ready to go all out and to do anything merely to regain acceptance by the Nazi Party and the SS.

In the lower echelons of the SS the principal places within the confines of Germany where members could acquire blood cement were the concentration camps. When SS members after this conditioning experience were considered reliable enough, they were sent abroad into the occupied countries where they were called upon to perform similar crimes inside and outside specific camp areas.

There were instances in which men ended by committing the very crimes they had been most vocal in disapproving. Dr. Gerhard A. H. Rose, vice-president of the Robert Koch Institute in Berlin, in regard to the typhus experiments on prisoners, and Colonel Karl Von Bothmer in the case of the shooting of civilians without trial in occupied countries are significant examples. Such instances were obviously the result of group pressure although no overt coercion was brought to bear. This illustrates that an important fact concerning motivation with which we are familiar in ordinary crime applies also to war crimes and to these ideologically conditioned crimes against humanity—namely, the fact that fear and cowardice, especially fear of ostracism by the group, are often more important motives than simple ferocity or aggressiveness.

The master crime to which the SS was committed was the genocide of non-German peoples and the elimination by killing, in groups or singly, of Germans who were considered useless or disloyal. In effecting the two parts of this program Himmler demanded and received the cooperation of physicians and of German medical science. For this trend of research in Nazi Germany—namely, that toward developing scientific methods of destroying and preventing life—I have proposed the term "ktenology," the science of killing.

In the course of this ktenological research, methods of mass killing and mass sterilization were investigated and developed as well as methods for rapid and inconspicuous individual execution. A committee of physicians and medical experts headed by Dr. Karl Brandt developed various methods of extermination by gas. At first carbon monoxide was used, later cyanide gas ("cyclon B") with occasional use of warfare gasses for which this program supplied human experimental material. Of the individual methods of inconspicuous execution, which were usually carried out in camp hospitals by medical personnel, the most widely used was the intravenous injection of phenol or gasoline. This, however, left a tell-tale odor with the corpse which made it an undesirable means of executing prominent prisoners or high-ranking Nazi Party personnel where secrecy was essential.

The triumph of that part of ktenological research aimed at finding a method of inconspicuous execution which would produce autopsy findings indicative of death from natural causes was the development of intravenous injections of a suspension of live tubercle bacilli which brought on acute miliary tuberculosis within a few weeks. This method was produced by Professor Dr. Heissmeyer, who was one of Dr. Gebhardt's associates at the SS hospital of Hohenlychen. As a means of further camouflage to prevent the SS at large from suspecting the purpose of these experiments, the preliminary tests for the efficacy of this method were performed exclusively on children imprisoned in the Natzweiler Concentration Camp.

It is clear from the foregoing that we are dealing here with a generalized eruption of aggressive, destructive activity which invaded all spheres of life, including the physician's office. The resulting attitudes brought about a peculiar perversion of the concept of death, a perversion which can be described as an idolatrous delight in death, for which I have coined the word "thanatolatry."

This heathen concept, somewhat reminiscent of Voodoo beliefs, expressed itself in many ways. The blood-and-soil theory is the best known example. According to this theory, developed by Rosenberg and Darré, and widely believed in Nazi Germany, soil in which people of Germanic race were buried itself became German and in turn also could give German characteristics to people who nourished themselves from that soil. Goering's statement, made early in the war, that

"with every German airman who is killed by the enemy our Luftwaffe becomes stronger" is another example.

Dr. Karl Brandt, plenipotentiary in charge of all medical activities in the Reich, when asked about his attitude toward the killing of human beings in the course of medical experiments, replied, "Do you think that one can obtain any worth-while, fundamental results without a definite toll of lives? The same goes for technological development. You cannot build a great bridge, a gigantic building—you cannot establish a speed record without deaths!"

In a similar vein many SS men took a curious pride in the fact that even in peacetime they had many fatalities during "realistic" military training. Human bodies were encased in the concrete of fortifications and bunkers as if such bodies could give strength to inanimate matter. Himmler himself believed that strength could be derived from inflicting deaths and remaining unmoved. In his famous or, rather, infamous speech to his SS generals in Posen on October 4, 1943, he said:

> I will now talk to you here in all frankness about a rather grave chapter. Among ourselves it should be mentioned quite frankly and yet we will never speak of it publicly . . . . I mean the clearing out of the Jews, the extermination of the Jewish race. It is one of those things that is easy to say. "The Jewish race is being exterminated," says every party member. "That's quite clear. It is our program, elimination of the Jews, extermination—we do it." . . . . Of all those who talk that way nobody has witnessed it, nobody has stood through it. But among you, most of you know what it means when 100 corpses are lying together, when 500 lie there, or when 1,000 lie there. To have lasted through this and—apart from exceptions caused by human weaknesses—to have remained decent fellows,[3] that has made us hard. This is a page of glory in our history which has never been written and is never to be written.

It is one of the laws of psychology, which is in harmony also with similar more general physiological principles, that destructive urges of great magnitude and depth and destructive concepts arising therefrom cannot remain limited or focussed but must inevitably spread and be directed against one's own group and ultimately, against the self.

Examples of this self-punitive consequence are the murderous and hateful relationships which finally broke out among the ranks of the SS themselves. This ultimately and inexorably brought down the destruction of the group and the individuals who composed it—a destruction expressed in the marked turnover of personnel, many of whom found their deaths in SS bunkers at the hands of their former comrades. They were those who lost in the constant fratricidal struggle which was euphemistically termed "the self-selection of leaders" (*Fuehrer-Selbstauslese*).

There is an "all or none" law of fundamental psychological attitudes. A man cannot for long be criminal in one type of relationship and decent in others. The destructive drive, once unleashed, is bound to engulf the whole personality and occupy all its relationships. Himmler himself, with a remarkable degree of insight, summed up the whole case when he said in his speech to his generals on October 4, 1943, "We have become—I say that now behind locked doors and this is intended only for this small circle—a very corrupt nation."

We must see in the destruction of the morals, the institutions, the ideals, and the cities of Germany the ultimate realization of this destructive drive which was in no other organization of the Nazi state so limitlessly unleashed as it was in the SS.

The question now arises whether these destructive drives formed the main motivation of Nazism or whether they were merely superimposed on, or formed the superchargers of, other aims and goals. There was, of course, the one over-all conscious aim and goal—to gain power and complete control, first over the German people, then over Europe, and finally over the world, which was in itself a basically destructive and aggressive conception.

The determining elements of Nazism, apart from the fundamental aim and goal of complete domination of Germany and genocide of all non-Germanic peoples, were not any additional specific articles of doctrine or contents of thought, but rather cer-

[3] What is probably meant is "in dealing with each other," a phrase which recurs in other connections in this speech.

tain specific attitudes or modes of thinking. The most important and basic element of these attitudes was an intense hostility toward spiritual and rational modes of thinking and behavior.

This Nazi hostility toward spiritual and rational attitudes is the same basic hostility to spirit, culture, intellect, and reason which is inherent in the unconscious mind where this and other destructive drives are dormant. All these destructive drives are repressed and sublimated in the mature individual as long as he acknowledges guidance by spiritual and rational values. The disruption of spiritual values and of the value of reason is therefore one of the prerequisites for release of primordial destructive drives in the adult individual. And it is not surprising that the Nazis in their effort to release and utilize these drives made a concerted attack against these two inhibiting forces, spirituality and reason, which in the mature individual and in mature civilized societies prevent the eruption of the primeval destructive drives.

The first open attack was against religious-spiritual and humane ideals which were derided as weaklings' and slaves' morality; and a new "strong man's religion," the SS religion with heathen trappings and Hegel's worship of the strong, was substituted.

A systematic propaganda campaign to break down superego values was directed at the entire population, including children. A ghastly example is a widely used school book on applied mathematics, on the high school level, entitled *Mathematics in the Service of National-Political Education*(1). The choice of problems in this mathematics book was designed to break down the taboo against mass killing by formulating the problems in terms of mass killing, as when (on page 75) pupils were asked to compute how much phosgene would be needed to poison a city of a certain area and of a specified population, with special attention to the average rate of breathing in relation to the atmospheric concentration of the gas. The book also attacked normal and desirable compassion for the sick and crippled by setting problems in terms of distorted statements of the cost of their proper care and rehabilitation, asking, for instance, how many new settlement houses could be built and how many marriage-allowance loans could be given to newly-weds for the amount of money it cost the state to care for the crippled, the criminal, and the insane.

The taboo against promiscuity and disruption of family life was broken by the notion of the "foundation of life" (*Lebensborn*) which was to flow freely in the interest of the "State." Thus, the religious-humane-cultural superego common to all civilized peoples was replaced by an exclusively tribal superego. The psychiatrist stands in amazement before the thoroughness and completeness with which this perversion of essential superego values was accomplished in adults.

The explanation of this phenomenon is twofold. First, it may be that the decisive importance of childhood and youth in the formation of essential superego values may have been overrated by psychiatrists in a society in which allegiance to these values in normal adult life was taken too much for granted because of the stability, religiousness, legality, and security of the 19th Century and early 20th Century society. It may be that the lesson learned in youth has to be continually relearned in adult life in order to be durable, and that the ideals acquired in youth must be continually striven for again in order to remain valid and desirable.

On the other hand, however, it must be admitted that probably much more of the old tribal superego has remained alive in Germany than was noticeable on the surface. It was never thoroughly replaced by the religious and humane-cultural superego which other civilizations accepted more wholeheartedly. Therefore, the shift of superego values toward the exclusively tribal ones was easier in Germany than it would have been in other nations. Be that as it may, it is definite that this regression of superego ideals from the religious-humane to the tribal constituted the most important step in the Nazification of Germany; and it is obvious that the opposite step would be the most important one in the de-Nazification of Germany.

The next, more insidious, attack was against all modes of rational thinking and behavior, and indeed, against reason itself.

Reason and logic were decried as cold intellectualism, reasonableness as weakness. Teachers and educators conspired in the general campaign against logical thinking. Nazi school books are full of *non sequitors,* as if to train children in illogical thinking.

With moral, or superego, values perverted and reason discredited, the stage was set for the direct and uncontrolled release and the conscious encouragement of the unleashing of instinctual drives. This encouragement was given in the form of seduction. The more subtle form of this seduction was a peculiar cult glorifying the pleasurable satisfactions derived from the release of instinctual energy which was established.

Conscious destructive thinking in regard to all interhuman problems gained more and more prevalence among all those who became "infected" with Nazi ideology. The continuation of thinking in terms of destruction as the solution of all problems is today the best way to tell a Nazi from a non-Nazi.

All this disastrous propagation of destructive thinking was a means of preparatory seduction to destructive activity. This was early combined with more direct seduction to destructive physical activity calculated to let the novices taste the primitive satisfactions obtained from regression to infantile-sadistic patterns and to keep that taste alive in the initiated. It was for this reason that the training and indoctrination centers of the SS were always attached to concentration camps.

People can be more easily seduced to lower levels of emotional expression than educated to higher ones. Group and mass sanction played contributing roles in the process of seduction. Especially during initiation, the Nazis always saw to it that the worst atrocities, the so-called *"Sonderaktionen"* or special actions, were always committed by groups. The individuals who, once they were in the SS or similar formations, did not succumb to the "group polarization" were few.

However, the over-all result that Germans thoroughly infected with Nazism could, as Himmler himself expressed it, derive strength and joy not only from the act of killing but also from the process of gazing upon heaps of 100, 500, or 1,000 freshly killed corpses with frank enjoyment or with a veneer of rationalization was the combined result of indoctrination, seduction, and sanction—or, expressed in Pavlovian terms, conditioning.

One of the main sources of sanction was the group—in particular, the participating group. However, a sinister type of sanction came from a surprisingly large circle of ostensibly nonparticipating women, especially women close to SS and other activist circles, although not themselves enrolled in the SS or other activist organizations. Dr. von Baeyer (2) has pointed out this role of women in Nazi society with great clarity.

In summary, we found that there was a widespread release of destructive drives and destructive activity in the German people under the Nazi régime caused by the combined effects of (1) indoctrination with antispirituality resulting in a shift of superego values away from the religious-spiritual-humane toward the exclusively tribal (the *"Deutschland Ueber Alles"* doctrine); (2) indoctrination with antirationalism resulting in the discrediting and abandonment of reason as the main instrument for decision by individuals; (3) seduction resulting in pleasurable release of repressed instinctual drives; (4) sanction, namely, group sanction and sanction by the nonparticipating larger part of the female population—resulting in a pleasurable absence of guilt feelings.

Observation of the Germans during the Nazi régime indicated that they represented a group in which instinctual destructive drives can be more easily released than they can be in most population groups under comparable conditions of indoctrination and seduction by propaganda. I wish to emphasize at this point that I do not at all consider this trait as a biological or racial characteristic, but as the result of social, cultural, and political conditioning. I am therefore using the word "Germans" or "German people" in this connection as a term denoting members of a specific social, cultural, national, traditional unit—the German state or community—and not as a term denoting descendants of a particular racial or familial ancestral strain.

The conditioned aggressive behavior of the Germans was not a natural overflow of ex-

cessive ferocity but had to do with a more complicated process concerned with the higher levels of integration—the psychic control mechanisms rather than with the instinctual drives themselves. It is indeed in these control mechanisms rather than in the instinctual drives themselves that we have to look for the reason for this disastrous German trait. It is when we examine these psychic control mechanisms that we find the greatest degree of difference between members of the German cultural sphere and those of other, especially Western, cultural groups.

First of all, social-philosophic *"Weltanschauung,"* in other words, superego notions, have a greater guiding value to the German than to members of other cultural groups. This trait, of course, has its asset side. If the superego values believed in are good—for instance, religious, spiritual, and humane—then the particular German has a greater chance of becoming a saint than have members of other groups. The only trouble with predominantly superego-determined guidance of the personality is that the superego, even at best, is the least deeply anchored part of the personality, therefore the least stable and reliable unless it is continually reinforced by external social-moral forces such as religion, law, and public opinion. The superego structure is, therefore, in peril whenever these established guiding forces weaken or are in the process of being undermined, shifted, or perverted, and becomes itself open to undermining, shifting, or perversion even in adult life—a fact which is probably more important than we have been aware of heretofore.

The most important deficiencies of the members of the German social-cultural system, however, lie in that part of the personality whose function it is to deal rationally with reality in a responsible and relevant manner—that is, in the ego. A good deal has been observed with reference to the ego structure of individuals bred and integrated into the German social-cultural system. Brickner(3), especially, pointed out clearly that one of the outstanding features of the German culture is a resentment of reality and a denial of it which he compared to the attitude of the paranoid individual in reference to reality. A propensity for fanatical and even delusional thinking in Germans is indeed very striking to those who have come in contact with them. It exists not only among the defendants in the recent trials but also in the population at large.

Linked with this denial of reality is a widespread antirationalism obviously originating as a spontaneous defense but worked up into a policy designed to crush any attempt at exercise of the basic ego functions which might interfere with the denial of reality. With this unrealistic and antirational attitude go an unwillingness and an inability to accept personal responsibility.

A fourth trait is probably a consequence of the other three. This is a disinterest in the relevant aspects of life with a preference for certain irrelevant ones.

In other words, we have here the result of a social and cultural molding of the German personality in which, somehow, the ego part of the personality has been insufficiently developed or has been crushed by educational, social, or other forces. What we have left is a weak ego with a vastly overdeveloped but, of necessity, unstable superego which is superimposed over this weak ego and over a probably normal id portion of the personality. The emptiness of the ego sphere is the most striking finding which differentiates members of the German cultural group from members of other cultural groups. With this weakness of the ego, of course, goes the need to receive the main motivational stimuli from spheres of the personality other than the ego—that is, from both the superego and the id.

One of the most sinister traits of the Hitler régime was that it utilized a craving for irrelevant excitement by these personalities with weak ego in its system of seduction described above. It was, apparently, a function of the more spectacular atrocities in concentration camps, especially in Auschwitz, to provide this type of excitement. The most spectacular of the mass atrocities were called *"Sonderaktionen"* (special actions). One of these, practiced particularly in Auschwitz, was the burning of live prisoners, who were often children, in pits measuring $20 \times 40 \times 50$ meters, on piles of gasoline-soaked wood.

The reaction of the SS to the ghastly

shows offered and eagerly watched at Auschwitz was a peculiar mixture of enjoyment and detachment. Most revealing of this reaction is the diary of Professor Doctor Hans Hermann Kremer, a most interesting source of psychiatric documentation.[4]

I am of the opinion that the fundamental disturbance in the social-psychological structure in Germany is an ego disturbance. Where does it come from? We know, especially from our experience in military psychiatry, that anxiety is one of the most important ego-disrupting forces and we have learned about its interrelationship with aggressiveness: aggressiveness generates anxiety, and anxiety in turn generates aggressiveness. There is suggestive evidence that anxiety is indeed a more commonly predominant feeling in Germany than elsewhere, in children as well as in adults. Investigations are necessary to determine whether this anxiety relates to historical circumstances, to geographical circumstances, or whether it is fundamentally based on the structure of the German family.

What are the practical measures which we can take in reforming the social-psychological situation in Germany? First of all, further studies are needed. I hope that in these considerations I have indicated a few leads for further research. Yet already we have learned enough to know that, most of all, mature guidance on the part of the free nations is needed. For that purpose we must maintain our own maturity. Maturity is a level hard to maintain. Regression is all too easy and pleasurable and the danger is that our German patient may again forsake development of his ego in order to submit once more to another ephemeral neo-superego with a new orgy of release of instinctive destructiveness.

It is a recent and significant trend in medicine including psychiatry, to regard prevention as more important than cure. Observation and recognition of early signs and symptoms have become the basis for prevention of further advance of disease.

The question may rightly be asked: What should a psychiatrist assigned to the United Nations—if we may anticipate such an event—be looking for in order to find out whether a destructive-aggressive outburst may be expected in any member nation? On the basis of our studies in Germany, four signs may be regarded as danger or warning symptoms which might prompt such a psychiatrist of the future to recommend treatment.

The first sign is the prevalence of thinking in destructive rather than in ameliorative terms in dealing with social problems. The ease with which destruction of life is advocated for those considered either socially useless or socially disturbing, instead of educational or ameliorative measures, may be the first danger sign.

A second and probably more basic symptom is the prevalence of fear as a motivating force both within the social unit and in the relationship of the social unit to the outside world. We found fear to be one of the most important motivations for those aggressive outbursts which constituted war crimes. The most significant attitude of the nation and the group committing war crimes was that of fear.

We have learned that fear is one of the strongest emotions human beings are capable of. Fear has greater psychosomatic reverberations than other emotions. In any social setting whenever fear is allowed to become a socially motivating force, aggressive-destructive outbursts are to be expected. Fear generates aggression, and aggression in turn generates anxiety and fear.

Whenever within a society fear becomes a significant socially motivating force in the dealings of individuals with each other and in the reactions of society as a whole, it should be interpreted as a significant danger sign.

The third sign is tied up with the second. It is the restriction or abolition of the rights of the individual within a society. Whenever these rights are curtailed or abrogated there are new inroads of fear within the society. The fact that members of the SS were individually right-less, that they could be broken easily from officer's rank to enlisted man's rank, gives additional reality to the motivation of fear in contributing to aggressive criminal behavior by members of the SS.

The fourth sign is the lack of freedom of information. The destructive-aggressive be-

[4] Quoted elsewhere by the author (4).

havior in Germany was partly nurtured by the carefully spread notion that the new code of universal destructiveness was also accepted by other nations—only in a less "open" manner. This misconception based on misinformation about the outside world which was accomplished in Germany by the exclusion of news sources from the outside is difficult to eradicate even today. While members of a free society may freely gather their information to the limits of their natural curiosity, the restriction of access to information by any nation should be regarded as a danger sign of potential aggressive-destructive behavior.

It will be left to future society to see whether nations so diagnosed could be treated—and if necessary even certified, committed, and confined. To the extent to which we may be able to make such an arrangement, we may be able to prevent wars and destructive revolutionary outbursts within society.

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THE HOLISTIC APPROACH IN PSYCHIATRY [1]

ANDRAS ANGYAL, M. D., Boston, Mass.

I am going to describe a way of thinking about problems of human behavior, an approach which has been variously termed organismic, psychobiological, configurational (Gestalt), or holistic. Other theoretical orientations will be referred to only insofar as by comparison with them the holistic approach can be made to stand out more clearly. The examples which will be used may illustrate how this approach applies to the problems of psychopathology and therapy.

It is characteristic of the holistic approach that it views the human being as an organised unity and seeks to understand various phenomena of human behavior in terms of the *underlying organisation*. Thus the concept basic for the holistic explanation of behavior is that of *organisation* or *integration*.

The term organisation is not equivalent with the sum total of the relationships that may exist between parts. "Relationship" in its conventional meaning involves some type of one-to-one connection between two factors such as: A is larger than B, or A is cause of B, or A originates from B. One may be able to discover a very complicated net of such relations and yet a unifying pattern would not emerge. If, *e.g.*, a number of objects are arranged in a straight line, we may describe any number of relations between these objects, such as their relative distances from each other, without ever arriving at the concept of linearity. Linearity is not a relationship but a *type of order*. A type of order—which we may term a *system*—is a logical genus different from a relationship. The type of order that exists in a given totality implies an organizing principle: *the system principle*. The system principle of a circle is the equidistance of its points from the center. It is the presence of an organizing system principle that distinguishes a whole from a mere aggregate of items. If one states that the basic characteristic of the organism is to reach and maintain a state of homeostasis, or when one maintains that all forms of human activity fall into the category of pleasure seeking and pain avoidance, of love and hate, or again when one claims that the mainspring of human activity is a striving for superiority, one actually attempts to define the broadest system principle that governs human behavior. Whether the principles that were proposed by various students are correct or not—or whether they are more or less close approximations of the correct formulation—is not important in the present discussion. What is important here is only to know that some sort of an over-all pattern, a system principal, must exist: otherwise the person would not be a true unified whole.

In studying an individual case it is not sufficient to refer to a general formula of human behavior: we have to formulate the individual pattern of personality organization which is specific to that particular person. We do not satisfactorily understand a person as long as we cannot find the unifying formula of his behavior. This formula will be some individualized version of a universally valid general pattern.

The unity of the person, however, does not imply homogeneity. An organization requires not only an organizing principle but also a number of parts that are arranged according to this principle. The relation of the parts to the whole has a remarkable characteristic. The items that enter into the formation of a whole do not enter with all their intrinsic qualities but, so to say, through the occupancy of a *position in the structure of the whole*. Thus we may arrange a number of objects in a straight line and it will make no difference for the geometrical quality of this whole what the colors and weights of these objects are as long as they are properly arranged. In applying this to the person two actions can be said to have the same positional value if they represent two different means for reaching the same goal or two equivalent expressions of the same emotional

[1] Read at the 103d annual meeting of The American Psychiatric Association, New York, N. Y., May 19-23, 1947.

attitude. Certain changes in symptomatology that occur spontaneously or during therapy, are based on the similarities of the positional value, of the function or meaning of the successively appearing symptoms.

To explain a phenomenon in terms of mechanistic causation means to establish a one-to-one relationship between two factors, between the cause and the effect. On the other hand, the explanation of a phenomenon in a holistic frame of reference means, first: finding the context in which the phenomenon belongs, *i.e.*, finding a whole of which that phenomenon is a part, and second: defining the position (function or meaning) which this part has within the whole. Thus in a psychotherapeutic situation the therapist is first presented with a set of symptoms. These symptoms may appear first as discrete units seemingly unrelated to each other. In the course of the work, however, a formula may emerge which connects some of the presenting symptoms as organic parts of a larger unit. From this point on the symptomatology begins to "make sense." Recently I was working with a person who among other symptoms showed a tendency to phantastic pathological lying; obsessive stealing; an overwhelming desire to appear distinguished in attire, education, speech, and manners; and a great deal of anxiety. Studying this person, rather convincing evidence accumulated pointing to a common meaning of these symptoms. This person has a strong feeling of being surrounded by enemies and seeks security by attempting to disguise herself as one of the enemies with a concomitant almost continuous fear of detection.

In this attitude each of the symptoms that were enumerated above seem to have a positional value, a part function. The same process is repeated with regard to other symptoms which are recognized as parts of another organization with its own formula. As the symptoms are gathered into a limited number of organizations, further understanding is gained by recognizing these organizations as parts of a still broader formula. In actual practice, of course, this process does not take place in this schematic and orderly fashion.

Each part of the whole has its own organization, its own system principle, and its subparts. The organization of personality is a hierarchical one. In this hierarchy each part has a twofold orientation, a twofold function: 1. It organizes its parts, fits them into position according to its system principle. 2. It functions as a part in a superordinate system and tends to fit itself into position within this larger system. Even the personality as a whole has this double function: It asserts itself as a whole and it fits itself as a part into the larger organizations of society, culture, and the world in general. This double orientation reflects itself in all attempts to formulate the broadest system principle of the person: self-preservation—preservation of the species, self-assertion—love, will to power—Gemeinschafsgefühl, autonomy—homonomy.

The term "hierarchical organization" refers to the fact that the whole person organized under a broad formula contains parts organized under more specific principles; these in turn contain parts of still greater specificity until one finally arrives at the single items of behavior. This formulation might suggest that one can represent personality organization diagrammatically, let us say, by a large square, subdivided into smaller squares, each of them with its own subdivisions and that one could place then each behavioral item into its larger pigeonhole. This, however, is not the case. Although such diagrams—just as the classical Freudian diagram of the topology of personality—may serve to visualize *some* aspects of personality organization they do not take into account several important features of this organization.

The first point to be made is that an item of behavior cannot be placed justifiably in any single category because, as a rule, it functions as part of not one but of several systems. The phenomena of "multiple motivation" or "overdetermination" of behavior reflects this situation of manifold embeddedness. A given symptom may arise as an expression of a repressed sexual desire and is thus part of this particular system. The same symptom may then be utilized by the person as a means for getting attention. I am referring here to the analytical concept of secondary gain. Secondary gain itself is just one instance showing that one item may belong to several systems. However, this mul-

tiple embeddedness is a significant characteristic of personality organization in general.

When we say that a symptom is "deeply rooted" we mean sometimes that it has its root in an issue that is very important to the person. In other instances, however, this expression means that the symptom has many roots and is fed not by one but by many personal attitudes and desires. It is the nature of the organism to bring all its part functions into a successively closer organization so as to achieve unity even if this tendency is not always successful and may cause entanglements. This is probably the cause of the presumably high correlation between the duration of a neurosis on the one hand and its severity and its lesser therapeutic accessibility on the other. When a symptom or a nonadjustive behavior makes its appearance the person tends to bring it into relationship with all his partial functions and in so doing may permit it to grow more and more roots. Symptoms, as well as any specific behavior or attitude, vary greatly in the number of such roots. One can find cases in which a symptom seems to have practically only a single root. An emotional disturbance arising after a sudden and severe trauma, like some forms of war neurosis, or a phobia that clears up dramatically after its origin has been recalled (*e.g.*, in hypnosis) are cases in point. Unfortunately, the therapist rarely meets with such simple situations. Much more frequently he finds that even a convincing discovery of what seems to be the essential basis of a nonadjustive behavior may not be followed by improvement. The reason for this lack of therapeutic effect may lie sometimes in the superficial intellectual nature of the insight. In most cases, however, it lies in the fact that the many secondary roots of the symptom have not been exposed.

These roots have to be "dug up" through a process of tracing the manifold ramifications of the patient's attitude and finding how they converge on the present nonadjustive behavior. The analytical concept of "working through" refers largely to this prolonged laborious process which is necessary because of the interpenetration of systems.

At this juncture it may be pointed out that the holistic explanation implies a concept of determinism different from that implied in the mechanistic causal explanation. Mechanistic determinism means that if all the antecedents are given there can be only one result. This is strict determinism. In the holistic frame of reference one also assumes that events are lawfully determined. There is this difference, however: Since a part is defined by the whole insofar as its position in the system is concerned, this position can be filled by different individual items and still be in accordance with the system principle. Thus, the expected effect is not strictly defined, but only falls within a *range of possibilities*.

In the person we are dealing not with morphology, but with processes. The person represents a dynamic organization of great fluidity which defies any attempt of a diagrammatic representation. Rearrangements and shifts of emphasis are continuously taking place in the process of living. From infancy to adulthood there is an increasing differentiation and reorganization of the differentiated parts. The life history of the person represents a branching out of the original organization into increasingly numerous channels and an increase of relatedness between them. Personality is a time-gestalt, a temporally extended organization. Some students may place the emphasis on early childhood experience, others on the structure that exists at a given moment; but a satisfactory analysis of personality requires the biographical tracing through of the main branches of personality organization.

The organization of the whole is not merely a descriptive characteristic but has a dynamic function. The system principle exerts a dynamic influence by creating and maintaining a certain arrangement of parts. If a part function is not in accordance with the system principle, then there is a strong tendency to bring the particular function in harmony with the system principle (Law of Prägnanz); and if in a system some of the required positions are not filled there is a tendency to fill them; in the terminology of Gestalt-psychology one can say that open gestalts tend to close. Any need situation is an instance of an open gestalt that tends toward closure.

The interaction between the past, the present, and the future in the life history of the person is a problem of wide scope which can-

not be adequately discussed in this paper. I will only mention a few points of theoretical and practical interest.

The influence of the past on the future as we understand it at present may be expressed in the following simile: The early experiences of the child function like a motion picture that is projected on the subsequent experiences so that the latter become a combination of reality and fantasy, of present and past: it is as if a motion picture were projected on a landscape instead of on a white screen. If the child's early experiences involved exposure to hostility he will see elements of hostility in every new situation. The new experience thus compounded in turn determines the subsequent experiences: it becomes a new fantasy to be projected on the subsequently encountered situations. There is an astonishingly small amount of reality in our perceptions of each new situation and an astonishingly large amount of fantasy created through an organization of the past experiences. I was recently impressed by the striking demonstrations of Professor Ames at the Dartmouth Eye Institute which illustrate this point convincingly in the field of visual perception. Another point pertains to the possibility and effectiveness of a new organization of experience. As every good therapist knows, the success of the therapy depends not only on detecting the part that fantasy plays in the patient's ways of experiencing reality but also on creating new experiences of a more wholesome nature. These experiences will then in turn function as models, as wholesome fantasies, supplementing and counterbalancing the earlier one-sided experiences and thus permitting the person to take a more discriminating attitude toward the new situations he encounters.

There is one mode of interaction of earlier and later experiences that I would like to stress because it seems to have been neglected and yet appears quite important. This mode of interaction is best illustrated by one kind of effect which a severe trauma may have on a person. Alongside with cases mentioned before of acute pathological reactions which readily yield to treatment we find cases where the trauma is followed by the appearance of a full-fledged neurosis which requires extensive treatment. We tend to explain such cases by assuming the existence of a neurotic structure prior to the traumatic experience so that the latter is believed to have functioned merely as a precipitating factor. While this explanation is frequently true we also find cases where the trauma is followed by a severe neurosis but which present no evidence of any marked neurotic development in the person's past life. The assumption of latent neurotic trends in such cases is a forced one and adds little to the understanding of the condition. I would like to suggest an alternate explanation for this kind of onset of a neurosis. The traumatic experience creates a new model for perceiving the world and responding to it, *e.g.*, as to a constant threat of hostility and destruction and of helplessness in the face of this threat. This neurotic pattern becomes a powerful organizing principle, not only for the future but also for the *past* of the person. Past experiences which were perhaps potentially traumatic but were organized in such a fashion that actually they remained harmless are now drawn out of their previous organizational positions and are fitted into positions within the new neurotic pattern which gives them permanency. From then on they begin to function *for the first time* in the person's life as truly pathogenic factors. By force of this retroactive organization the newly created neurotic pattern can obtain sustenance from the past even though this past itself had contained no well-formed neurotic pattern prior to this reorganization. This would be a striking example of the present influencing the past. Admittedly this is not a sufficiently verified hypothesis, but it seems plausible and offers possibilities for new approaches to problems.

We may now briefly consider the manner in which a change in a given part spreads to other regions of the organism. We should keep in mind that the concept of parts has meaning only if it is restricted to the immediate part. To give an example, it would be meaningless to state that handing money to another person is a part of a person's ambitious strivings, even though the object purchased—a tool, a book—is to be used in the course of occupational training which the person has undertaken in order to improve

his social standing. A change that occurs at any point in the heirarchy of systems can directly effect only the neighboring systems. This may be called the *law of continuity of system action.* It is evident that this law has a direct bearing both on the theoretical problem of causation and on the practical problem of therapy. On the basis of this law we may state that attempts of tying up *directly* some physicochemical changes with some complex form of behavior are erroneous. If one neglects the intermediary steps one may bring into relationship members so distant that the connection between them remains entirely incomprehensible. Their only value is that of a statistical correlation the basis of which requires further investigation.

SUMMARY

The holistic approach seeks to understand the person on the basis of his organization.

An organization cannot be described in terms of one-to-one relations but in terms of systems. Systems are types of order, arrangements of parts according to a unifying principle, the system principle.

An item functions as part of a whole through the occupancy of a position; it has a positional value within the structure of the whole.

Personality organization is a hierarchy of systems.

Any constituent of personality may function as a part of several subsystems at the same time.

Holistic determinism allows for more than one single effect; it determines only the range within which the effect will fall.

In the life of the person interactions do take place not only in the direction, past-present-future, but also in the opposite direction.

The law of continuous spread of system action states that only neighboring systems can effect each other in a hierarchy of systems.

The holistic approach as outlined here does not contain assumptions about specific psychiatric phenomena but describes a way of thinking which I believe is fruitful for the clarification of psychiatric problems.

THE INTAKE INTERVIEW AS THE BEGINNING OF PSYCHIATRIC TREATMENT IN CHILDREN'S CASES [1]

JULES V. COLEMAN, M. D., GENEVIEVE B. SHORT, M. S. W.,
AND
J. COTTER HIRSCHBERG, M. D.
Denver, Colo.

The intake interview in children's cases is a dynamic process of interaction in which the thinking and feeling of the parent, disorganized by anxieties and social pressures, are provided free channel of expression within a therapeutic framework by the discriminating activity of the worker. The parent appears to come for treatment of the child's problems, but actually the impelling motive is almost always a personal problem of her own and there is sometimes a surprising disproportion between the intensity of the parent's complaint and the relative insignificance of the child's behavior difficulty. We recognize, however, that the parent who brings her child for treatment is not merely using the child as a screen or an excuse, and is really disturbed in feelings relating to the child. On the other hand, we have followed the policy of not limiting the parent to the special relationship with the child, leaving her free to go as far as she wishes and is able, in exploring her own problems. While this is a matter of treatment policy, it deserves special and early emphasis, for, as our case will illustrate, treatment policy determines the activity of the worker in the initial interview.

The intake interview serves at least 3 different functions, which need to be separated out before the proper subject matter of this paper can be considered. In the first place, there are many persons coming to the clinic who are unable to benefit by psychiatric treatment, or who need help with subsistence needs, or, in the case of children, with security needs, and are referred to other agencies; this then is a *referral service* carried out by the intake worker. Secondly, there are persons who need and can benefit from psychiatric treatment, but do not understand its implications, or are not ready to accept its demands, and need time and help in preparation; and this is the *process of preparation for psychiatric treatment,* which may be carried out by the clinic intake worker, or by a worker in a family or children's agency, or by a private physician or teacher. Finally, there is the *intake process itself,* in the most literal sense, by which the patient's request for help is recognized, the attitudes of initial resistance identified, the nature of psychiatric treatment clarified, and the function of the clinic interpreted. In other words, this is the initial treatment interview, and its application as the beginning of psychiatric treatment in children's cases will now be discussed.

However, we might mention in passing that psychiatric treatment of the parent is considered an integral part of the therapeutic process in children's cases. We see the child's problem as an element in the larger familial pattern of emotional disturbance. Difficulties in the marital relationship, for example, are almost invariably disclosed as of at least contributory importance, and are often found to be the primary factor in the child's problem. In any event, we offer the parent treatment, instead of advice, blame, or reproof. Usually it is the mother who presents the problem and comes for treatment, but occasionally the father follows through with the therapeutic program, and is often seen at some time or other during treatment in any case.

The first contact is usually made by the parent with the Mental Hygiene Clinic by telephone, at which time the source of referral is learned, identifying information and a brief statement of the problem are obtained, and an appointment is arranged at a later date with the intake interviewer. There

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From The Mental Hygiene Clinic, Colorado Medical Center, Denver, Colo.

is usually some lapse of time between the period of the initial contact and the first treatment interview, as determined by the number of patients we have on the waiting list. Although it was not a planned arrangement, being due to limitations of staff, we feel that this waiting period does have certain positive aspects. A parent sometimes calls for an appointment at the height of an emotional crisis when she is very unclear what help she wants, except that it serve the immediate purpose of draining off tension. With this accomplished and an appointment arranged, the subsequent "cooling off" period permits her to mobilize her feelings regarding the problem and decide if she needs assistance and, if she so decides, to be better prepared to use clinic service.

We think of the initial treatment interview, then, as the beginning of a relationship experience in which the preconceived ideas of the parent regarding the clinic and the attitudes of the parent toward the child are allowed free discussion, within a definite framework of worker activity. Within this framework, no limit is set on the problem area, and it is recognized that the feelings of the mother and her anxiety around the problem are of primary importance. We are not interested in the developmental history of the child or the personal history of the parent except as such information emerges in relation to the feelings and attitudes revealed in the parent-child relationship, and in the dynamic development of the therapeutic situation between worker and parent.

Some parents have a good understanding of clinic function, recognizing that the clinic is a place where one can talk through problems and deal with feeling. Others harbor the "magic wand concept"; they bring the child, the clinic cures him in some mysterious way, and they have no need to take any part in the process except to applaud. Others have the "prescription concept," *i.e.*, the child will be given advice and they will be given a formula which will produce a change in behavior. Others have the "bogeyman concept"; the child is threatened with the clinic as the "big bad wolf" which will frighten him into changing his behavior. The "organistic concept" is common, the parent feeling that physical disease must be the basis of the problem, thereby again dissociating themselves from responsibility. Finally, with the concept, "There must be something wrong with his mind," the parent cuts himself off entirely from the child, sometimes by identifying him with a mentally ill relative, or in the case of an adopted child, many of whom are brought to the clinic, by shifting the blame to the natural parents.

These misconceptions deeply influence the parent-child relationship and the rationalizations by which the parent is able to bring herself to ask for help. The anxiety aroused by the confession of failure, "I can't handle this myself. Others can manage their children, but I can do nothing with mine." This anxiety of social inadequacy and social disapproval leads to the development not only of rationalizations of one kind or another, but also of curious shifts in emphasis of feeling and attitude. A parent, for example, may show unmodified and uncompensated hostility toward the child in the first interview, but not again throughout the treatment process. Or, in other cases, the parent exaggerates the child's symptoms, in order to make them seem more important, as if for fear of ridicule as incompetent; or takes the opposite course of minimizing the symptoms to protect self-esteem in another way. Anxiety may also be expressed by inability to talk, inability to remember, uncertainty, confusion, and vagueness in the description of symptoms.

Hostility toward the worker is expressed in some cases; for example, in that of a 7-year-old girl who was referred by the family physician for enuresis. The mother recited, in a hostile manner, the many unsuccessful cures she had attempted and then remarked, "I've tried everything anybody has ever told me and nothing has worked," in a tone which implied, "I defy *you* to do anything about it either."

Then there is the dependent mother who may express complete helplessness regarding the problem, reject all responsibility and surrender to submissiveness. In one instance, such an attitude was found to cover homosexual feeling which gradually came to the surface. Then there is the parent with an intellectual but not emotional acceptance of her responsibility in the problem of the child. Or the rather rare parent who says,

"This is my problem, I have failed, I am the one who needs help."

In the intake interview, the worker deals discriminatingly with the feelings expressed, with the object of giving the mother an actual experience in treatment, thus initiating the treatment process. The intake worker will not always continue on as a therapist. Ideally, from the standpoint of therapeutic continuity, it might be desirable if he could, but flexibility on this point is necessary for administrative reasons. Where there will be a change of therapist, it is particularly important for the intake interviewer to avoid dealing with the relationship in any way which would tend to deepen it too rapidly. He must maintain a friendly, warm, understanding atmosphere without personalizing the relationship, but since this is in any case a requirement of therapy in general, it need not be further discussed here.

The following case is presented to illustrate what takes place in the initial treatment interview:

Mrs. B, a small woman, probably in her early thirties, came into the room, poker faced, failing to look at the interviewer directly. She seemed tense and on the verge of crying. She began by talking of the problem of the child, saying, "John doesn't want to go to bed at night, so I'm using a big stick on him as a last resort. The effect of the big stick is wearing off. Before using the stick, I tried reading to him, but the stories got him so excited he couldn't sleep. I've tried changing the schedule, putting him to bed later, but he still fusses and refuses to go to sleep. John has temper tantrums and is a nervous, irritable child. I think some of this is due to the fact that he wasn't breast-fed. I wanted to nurse him but my husband said definitely that I couldn't, he didn't want me to be tied down. I was tied down anyway with a baby—I continued having milk and begged Mr. B to say yes, but he remained firm. I've observed that breast-fed babies are usually happier and I think it's a shame that John had to be deprived. His formula agreed with him, however, and he developed normally. A few nights ago, Mr. B said that John is a potential criminal because he refuses to mind. What do you think, is there such a thing?" The worker replied that from what we know today criminals are made, not born, but that undoubtedly Mr. B's remark had upset her.

During this part of the interview, the worker did not need to ask questions, she did not permit herself to get into an intellectual discussion with the parent regarding the merits of breast feeding in relation to the happiness of the child. She did not give advice regarding the use of the stick or bedtime schedules, and yet she actively indicated the direction of her interest and pointed the way towards a further development of the basic problem with which the patient was trying to deal. She created a situation in which the mother was allowed to bring out her guilt over not breast-feeding the child, her hostility toward her husband, and her displacement of blame to him for depriving the child. Furthermore, she skillfully handled the feelings about the husband which were back of the direct question regarding the potential criminality of the child.

The interview then proceeded; the fear and tension of the mother diminished, as the worker accepted her feelings and indicated her understanding of their source. "I think John is acting the way he is because of the parents he has. Mr. B never knew a normal home life as a child, nor did I. My father was an architect who came west to seek health; he died when I was six. My mother struggled to keep a home for us—I was the third of 5 children—but she couldn't manage and we were placed with various relatives and agencies. I went to an orphanage where I remained until I was 14." Mrs. B continued with her own history at some length.

Here we see that the worker's understanding permits the mother to bring out the feeling of her own responsibility in John's problem and stimulates a discussion of her own deprived background as it relates to her present reactions. As the worker had not been critical of Mr. B, nor of her feelings of hostility, the mother feels safe with her and is then able to go on to say, "John isn't really the whole problem. I'm tense and nervous. I don't want you to think that I blame everything on Mr. B either. In the first place, neither one of us wanted John. Mr. B is 50 years old and has a married daughter. The beginning of my pregnancy was very rough on both of us, but we gradually became reconciled. Then there was the terrible row over breast feeding, then Mr. B's irritation over the baby's crying, then the temper tantrums, and now the going to bed problem."

The worker agreed with the mother that John was not the whole problem but did not attempt to narrow down the difficulty, and Mrs. B went on to say, "Mr. B is around home too much. He leaves for the office late, drops in for lunch, get home at 4:30. He is under treatment for hypertension—he gets irritable when discussing many general subjects, blows up at me, shouts and swears. He considers me a scatter-brain, never considers my opinion on anything worth listening to. About every 3 months we have a big fight, we can go about that length of time, then the accumulation has to come out. I've known ever since John was a baby that this sort of thing can't go on. We've discussed whether it would be better for John to give him up for adoption, but neither of us can face it. I've talked with my family doctor about divorcing Mr. B, but can't see it as a real solution. Every child is entitled to have a father—I didn't have one and I know."

At this point, it was explained to her that she could talk about these things with a regular worker for one hour each week while John was seeing a doctor, if she wished to participate in treatment. The worker indicated that she considered the mother

to be in need of treatment and yet gave her an opportunity for choice in the matter. The mother accepted this arrangement with considerable relief, since her problem had been brought into some focus and yet her guilt was being relieved by bringing the child for treatment as well as taking responsibility for change herself.

Within the framework of this interview, treatment was initiated by the worker chiefly in 2 ways; first, by taking up the problem of her hostility toward her husband and her guilt toward the child; and, in the second place, by letting her work out the problem area herself, and find a mode of participating in the total situation. There is movement starting from discussion of the behavior of the child with displacement of blame to the husband, to her sharing responsibility for the problem, recognition of guilt in regard to feelings of rejection of the child and, finally, expression of desire to have help with her own problems in the marital relationship as well as with the behavior of the child.

The therapists who carried on with this case for treatment had a clear picture of the attitude of the parents toward the child and the expectations of the mother from treatment. The parent had an actual experience of treatment, which started her moving in the direction of working through her immediate problems. The mother further had a new orientation toward treatment which carried over in her dealings with the child in relation to his treatment. The interpretation of treatment, as carried out in an implicit sense through the worker's activity, created no untimely or premature focussing of the problem, stirred up no unnecessary anxieties, avoided stimulation of guilt, and yet at the same time was sharp enough and definitive enough so that the mother was able to go on without any further questioning of the process.

There was no attempt made to delimit or define the mother's problems outside of the immediate situation, as would have happened if the history taking method of approach had been used. The interviewer was not imposing upon the mother any organization of the problem which the mother might not be able to work out for herself. At the time of the initial interview, we recognize that the patient's psychopathology is not in itself sufficiently descriptive of the treatment problem, but that equal consideration must be given to the interplay of forces in the total current situation. This is obviously of even greater importance in children's cases, where the parent-child relationship is acted out against the background of the marital relationship.

Our goal in psychotherapy with parent and child is actually not over-ambitious. We are not interested in bringing about any radical personality change, or in rooting out deep-seated characterological defects. The growth of the child is in itself a dynamic factor in the family constellation, and one is therefore dealing with a situation in which accumulation and distribution of tensions may be modified to a significant degree by what may appear to be a relatively minor therapeutic procedure. In any event, we are at all times careful to keep the problem concretely related to current realities, basing evaluations on an understanding of the psychodynamics of the persons involved, and their interrelationships.

In summary, we have described the intake interview as the beginning of psychiatric treatment in children's cases, indicating the multiplicity of factors to which consideration must be given in the interest of proper management. It is important to have some understanding of the prejudices and misconceptions of parents in relation to psychiatric help; of the various adverse parental attitudes influencing children's behavior; of the protective manifestations which parents bring to the task of dealing with their anxiety in the first interview; and, finally, of the clinic's treatment philosophy and goals by which the worker's activity is guided. We have discussed the problem of maintaining the first interview at a level which would allow the parent free expression of feeling while creating a framework within which therapeutic movement may take place. Finally, we have pointed out the importance of allowing the parent herself to discover the range of problems which she is able to deal with in the situation as given. The intake interview, as we have presented it, is more than an occasion for historical study and evaluation; it is more than a sample or demonstration of treatment; it is the beginning of the continuous dynamic process of treatment itself.

PSYCHIATRIC INTERVIEWING [1]

I. Some Principles and Procedures in Insight Therapy

JACOB E. FINESINGER, M. D., Boston, Mass.

The interview is the main vehicle of treatment in the various types of psychotherapy. Whether the method used is catharsis, suggestion, supportive treatment, insight therapy, or formal psychoanalysis, the organized and sustained therapeutic work primarily involves talk and emotional experience in a professional setting. Words as therapeutic agents elude conventional methods of assay and prescription. Even more elusive are the appraisal of feeling and the subtleties of the physician-patient relation, which are important in all branches of therapy and fundamental in psychotherapy. Communication, both verbal and nonverbal, and the physician-patient relation are the tools that must be adapted to the goals of psychotherapy. The goals are essentially the removal or alleviation of symptoms and the attainment of a better personal and social adjustment. This implies that the patient achieve and maintain the maximum use of his capacities in order to enjoy greater personal satisfaction and social usefulness.

Any therapeutic procedures worth consideration must obviously be able to cure or help the patient. What other criteria can be set up for procedures in psychotherapy? In the first place, the range of procedures must be great enough to cope with patients' individual variations. Flexibility is essential but need not imply vagueness. To the contrary, clear formulation is necessary if we are to develop procedures which are planned, consistent, repeatable, and teachable. Therapeutic procedures should preferably be related to our current understanding of the pathological processes and to the specific problem or disorder to which they are applied.

In working with the neuroses and psychosomatic disturbances, insight therapy appears to be the method of choice. It is only when it is impracticable or too disturbing to the patient that other methods, such as supportive or relationship therapy, are used. In 13 years of ward practice in a psychiatric unit of a general hospital, we have used insight therapy whenever possible, often with limited objectives. The treatment usually requires from 20 to 40 interviews, occasionally more. It has been our practice to use the vis-a-vis interview method.

In this paper, we shall focus on the procedures of interviewing that we have adapted and found useful in insight therapy in the psychoneuroses and in the psychosomatic disturbances. This form of insight therapy owes much to psychoanalysis, both in scope and in technical procedures. As in psychoanalysis, the therapy relies on an effective doctor-patient relationship for the production of material for interpretation and assimilation. The material is made up of behavior, talk, intonation, gestures and feelings; it includes the whole gamut of verbal and nonverbal reactions. The ultimate goal of insight therapy that we practice may be limited to a less fundamental rearrangement and enhancement of the personality than in psychoanalysis. When used in relatively brief psychotherapy, it seldom exposes the phantasies and memories that are most deeply repressed. As a rule, transference material and dream material are not used to the extent that they are in psychoanalysis. But there is nothing to prevent goal-directed procedures from being applied in a longer and more extensive treatment. And indeed, we have so applied them. In such cases, the patterns of the patient are followed in greater detail through the use of dream and transference material, relying constantly on the fundamental principles that we find helpful in insight therapy. These principles are the development and utilization of an effective doctor-patient relation, the use of goal-directed planning and

[1] Read at the 103d annual meeting of The American Psychiatric Association, New York, N. Y., May 19-23, 1947.

From the Department of Neurology and Psychiatry, Harvard Medical School and the Psychiatric Service of the Massachusetts General Hospital.
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This is the first in a series of papers on procedures in psychotherapy.

management, the focusing of material, and the use of minimal activity.

It is our experience that these procedures can be taught and that students can learn to apply them starting with their first patient. The teaching method that we find most effective consists of reading verbatim interviews of a current case in which the remarks of the doctor as well as the patient are recorded. In these supervisory conferences the methods of interviewing and management are formulated and discussed in reference to the situation as it is presented. Dynamic formulations of the patient's productions are elaborated, but the emphasis is on procedures—what to do. Teaching is most productive when the students actively participate in these discussions. The student learns that the very elements in his own behavior which make for success in the conventional social situation may be precisely contra-indicated in psychiatric interviews used for insight therapy.

The four guiding principles that we have found useful in insight therapy have been referred to above. The enumeration of specific principles in a field as fluid as psychotherapy may seem arbitrary and even challenging, but it is our impression that experienced therapists will recognize much in common between these principles and the rationale of their own working procedures. Working guides could be useful for other forms of psychotherapy. The extent to which such guides would include these four principles can be determined only by study and evaluation. These principles will now be discussed in some detail (see Fig. 1).

PRINCIPLES OF INSIGHT THERAPY

1. Development of Effective Physician-Patient Relationship
2. Principle of Direction
   Goal-Directed Planning and Management
3. Principle of Focusing or Channeling on Topics Relevant to Goals
   Charged Topics—Utilizable Material
   by
   Selective Indication of Interest by Physician
4. Principle of Minimal Activity by Physician Utilizing Maximal Initiative of Patient

Fig. 1.

1. The Development of an Effective Physician-Patient Relationship

It was Freud who first investigated the phenomenon of transference and its far-reaching implications in human motives and performance. This contribution has made us aware of the subtle but powerful forces operating in the contract between the physician and the patient. This mutual interaction permeates every phase of the treatment. Some of the elements of this relation can be recognized. The patient is aware of the doctor as a trained specialist whose job it is to help him, and towards whom he incurs financial or other responsibilities. He may react to the physical setup in which treatment occurs, and to many of the personal characteristics of the doctor. He is usually unaware of the significance that the doctor has for him in representing figures in his past, He rarely understands the meaning that the therapeutic situation carries in satisfying or frustrating his needs for dependence or independence. The doctor is aware of the patient's needs, and of a desire to help, but he may not be aware of all the elements in his own reaction to the patient and to the therapeutic situation (countertransference).

Of the many qualitative variants in this interaction there can be recognized two aspects which are fundamental for psychotherapy. The relation provides the support which enables the patient to face his difficulties during the therapeutic experience; it also contributes toward the tension under which the therapeutic process advances. In other words, it can be considered as a balance between the support and the strain necessary for the progress of the treatment.

During the first interviews, it is essential that the patient return, and it is desirable that he be willing to work with the doctor. The emphasis during these early contacts, therefore, is primarily on support, until a diagnosis has been made and therapeutic plans arrived at which are acceptable to both the physician and the patient. As treatment progresses, the relation will tolerate increasing strain. The doctor becomes sensitive to the degree of support needed at any moment to prevent the strain from becoming intolerable and thus blocking the treatment. It is our impression that a good measure of control of

this relation is possible in the hands of the skillful or well-trained worker. This matter will be referred to under the section on therapeutic goals.

Warmth gives support in the development and maintenance of the relationship; coldness and aloofness may defeat the therapeutic aim. Yet warmth does not imply the overemphasis of a purely conventional social interest or premature commitments and promises. In insight therapy, this type of unwitting, nonprofessional participation may interfere with planned therapy, and introduce unnecessary complications, especially in the area of patient management. It thus becomes important to steer the relation along professional lines. This is a frequent source of difficulty for the inexperienced therapist.

2. Principle of Direction

Goal-directed Planning and Management

(Fig. 2)

GOALS IN INSIGHT THERAPY

1. Ultimate Goal
   - A. Loss or Alleviation of Symptoms
   - B. Improvement in Personal and Social Adjustment
2. Intermediate Goals
   - A. Adaptation of Physician-Patient Relation: Balance Between Support and Strain as Required for Progress of Therapy
   - B. Production of Material
     1. Current Symptoms or Problems—Detailed Description
     2. Pattern of Reaction—Examination of Several Episodes
     3. Effect of Patterns on Current Adjustment
     4. Meaning and Function of Patterns
     5. Historical Development of Patterns
   - C. Interpretation of Material
     1. Step by Step Interpretation
     2. Summarizing Interpretations

Fig. 2

(a) *Ultimate Goal.*—The type of insight therapy under consideration is planned and directed by the doctor. The detailed work is oriented toward the ultimate goal of treatment which is the removal or alleviation of symptoms and the achievement of a better personal and social adjustment. Before therapeutic plans can be made, the tentative diagnosis is established, usually after physical and laboratory examinations have been completed. In addition to the formal classification of the syndrome, the diagnosis includes dynamics and defenses, with special emphasis on those mechanisms bearing on the doctor-patient relationship. The ultimate goal of treatment is established on the basis of this preliminary diagnosis, the patient's needs, and the doctor's clinical experience. It is formulated as soon as possible for each patient. In some cases, an early decision is made to limit the scope of the goal. Sometimes a change in the ultimate goal is indicated during the treatment. It is essential to keep the status of the ultimate goal in mind throughout the course of the treatment.

(b) *Intermediate Goals.*—As a guide for the work of each single interview or group of interviews, intermediate goals are formulated. These again are based on the problems and the material, and the psychodynamic patterns of the patient. The intermediate goals are selected from the three areas considered significant in this type of therapy. These are the doctor-patient relation, the verbal and other productions of the patient, and the working through of this material, with the aid of interpretation when necessary, so that the patient can accept and assimilate the implications and meaning of his experiences.

The first and basic goal has been described above under the heading of the doctor-patient relationship. As soon as the progress of the treatment is blocked, the doctor scrutinizes this relationship. He may decide that a shift is indicated, and this shift becomes, for the moment, an intermediate goal. For example, at a given phase of the treatment, the doctor feels that the patient is not discussing his real difficulties but is verbalizing irrelevant or trivial matters. The intermediate goal then would involve a change in relation, increasing the patient's state of tension to direct his efforts to the real issue. At another phase of the treatment, the same patient may be reacting with too great intensity, and may be having severe symptoms or be acting out his problems at home or at work. In this phase, the doctor plans a shift in the relation with emphasis on support. An emphasis on support may be especially needed in patients with psychosomatic disturbances and in the

psychoses. In these cases, it forms the rationale for the more active procedures which involve various degrees of participation by the physician and even the planned use of other resources and workers. The planned adaptation and use of the doctor-patient relation requires much further study.

The intermediate goals dealing with the production of material can be grouped in the categories that are summarized in Fig. 2. The first deals with the detailed description of the presenting symptoms, attitudes or problems, and of the situations or emotional factors which may act as precipitating stimuli. As a rule, the patient's complaint or another episode is selected for this inquiry. The emphasis is always on a free description of the details, especially those which are emotionally charged. When this has been achieved, the next step is to ascertain whether the current sample is unique, or is a repetition of an organized pattern of behavior. The preferred method is to have the patient focus on several exacerbations in turn and to determine the common features in the symptoms or problems on the one hand, and in the associated situations on the other hand.

When the patient has seen and recognized the patterns in his behavior and the similar or repeated modes of reaction, it is important to focus his attention on the effect of these patterns on his current behavior, and on the meaning or function of the patterns in his daily living. This aspect is often lost sight of, as pointed out by Whitehorn,[2] and yet may represent the most rewarding effort of the physician. Often the discussion and understanding of this material can be accomplished quite early in the treatment.

Another type of goal explores the reasons why the patient reacts pathologically, or why the precipitating stimuli have become pathogenic. It deals with earlier memories and phantasies that are associated to the disturbing stimuli and reactions. The goal includes the historical development of pattern, and throws light on what may be termed the etiological factors. The memories are traced back to find early charged or traumatic experiences. The degree to which this intermediate goal is pursued varies from patient to patient, and is determined by the scope of the ultimate goal. In cases in which extensive therapy is indicated, it may be pushed as far back as possible into the early historical material.

Repeatedly throughout the treatment, the intermediate goals are brought back into focus. Whenever the doctor finds the pursuit of a goal unproductive, it is usually safe to focus again on the current symptom, or on the disturbing experience related to it.

Great flexibility is used in selecting the intermediate goals, and advisedly several can be held in reserve. On the other hand, it is unproductive to jump at random from goal to goal, for by so doing, one may be avoiding the pertinent issues that are masked by the patient's defenses. Our experience indicates that it is better to pursue a given goal until it is exhausted or until there is some indication that is was not productive. As new topics appear in the course of the patient's browsing, they are noted by the doctor, even though he may not comment upon them. He considers whether the new topic is relevant to the intermediate goal. He further considers to what extent the material of this new topic can be utilized or accepted by the patient at the current stage of his insight and emotional tolerance. It is, as a rule, unwise to shift to topics that are currently irrelevant or nonutilizable, however much the new topic may intrigue the therapist in relation to the dynamics of the patient's symptoms. Patience in this matter is usually indicated. At some other time, when this material becomes utilizable and is pertinent to an intermediate goal, the patient's flow of talk may advantageously be channeled in the direction of this same topic. The direction by the doctor consists in large measure in timing his interventions. This type of selection gives us an illustration of the meaning of goal-directed procedure.

Step by step, as the patient's productions have clarified a topic, the intermediate goal may include interpretation of the material. As the treatment progresses, further interpretations are made and eventually summarized. Interpretation implies a great deal more than mere verbal formulation by the doctor—or even by the patient. We look for

[2] Whitehorn, J. C. The Concepts of "Meaning" and "Cause" in Psychodynamics. Am. J. Psychiat., 104: 289, 1947.

changes in the behavior of the patient as an indication that the interpretation has been effective. Premature interpretation can actually retard the therapeutic work. Interpretation should be well timed and not made glibly and readily. The first requirement is that sufficient material should have been produced to demonstrate clearly the interdependence that is to be interpreted. The second requirement is that the patient be ready to utilize the interpretation, or to accept its inference. For all but the simplest interpretations, it is well to wait until there is evidence that the patient has overcome some of his resistances. Evidence of this sort is provided when the patient is able to produce material in a charged area in which he had formerly been reticent. The material may have exposed the interdependence so clearly that the patient can make the interpretation himself. If this does not occur, we arrange the material for the patient, while still leaving to him the initiative for drawing the conclusion. If the patient repeatedly fails to draw the inference in the presence of clear evidence from the material, the doctor may decide to become more active in interpreting.

Dream or phantasy material is seldom used for interpretation excepting when a more extensive therapy is undertaken. Material that is nonutilizable by the patient can, however, serve as a lead for the doctor in the selection of future goals.

An example may clarify the selection of goals.

A 30-year-old married female was admitted complaining of anxiety feelings, nausea, and occasional vomiting. After complete examination, the diagnosis of mixed psychoneuroses was made, and insight therapy was decided upon as the therapy of choice. The first intermediate goal dealt with the exploration of the current exacerbation of her symptoms. Several similar reactions were investigated, and the interviews were devoted primarily to the description of the onset of her symptoms which were associated with sexual advances of the man whom she subsequently married. While working through this material, the patient's choking sensations disappeared, but nausea and vomiting increased. The next goal was to focus on her current behavior and to find out in what way it was inhibited by her symptoms. Subsequently, attention was focused on the function or meaning of the symptoms. Material was obtained which indicated that her symptoms served as an escape from facing her hostility feelings toward her husband, and that they also represented self-punishment for guilt for these hostile feelings. The significance of this material was indicated by summarizing interpretations. The next series of intermediate goals was concerned with her earlier relationship to male figures, especially her father. At this time, the patient was blocked. It was only after hostility feelings to the doctor were ventilated that she was able to describe early memories, principally concerned with angry feelings toward her father. Interpretations were made indicating the relation between hostility toward the doctor and similar feelings toward the husband and father. When this material had been worked through and interpreted, the symptoms improved. At this point, the patient was able to bring up significant details of the precipitating situation with her fiance, which had hitherto been inaccessible. The next goals, focusing on the earlier material, disclosed episodes with positive feelings toward her father, and feelings of rivalry toward her sister and mother. Working through this material resulted in marked improvement in the patient's symptoms. The work in this case represented about 40 interviews.

In planning and organizing our work with patients, we have studied the technical means at the doctor's disposal for guiding the flow of material at the appropriate time in line with the goals. To this end, we have used procedures which are based upon two principles: the principle of focusing or channeling and the principle of minimal activity (see Fig. 1). Obviously, no therapeutic guides can supplant judgment and experience. At the same time, it is our opinion that a general orientation derived from these working principles can serve to sharpen or point up judgment and to make it more critical even for the experienced.

3. The Principle of Focusing or Channeling

To pursue the intermediate goal, the doctor focuses the patient's efforts upon topics which are relevant. This can be brought about by perceptible changes in the degree of interest displayed by the physician. One must distinguish between the interest that the doctor may feel in all the productions of the patient and the interest that he shows to the patient, nonverbally or verbally. The display of interest on the one hand, and the withholding of any signs of interest on the other hand, are the chief means at the doctor's disposal for channeling the material. It is in this area that the inexperienced therapist often makes mistakes, by not realizing that all his comments, even the most indiscriminate and

casual, act as prompts to the patient. Unplanned intervention tends to make the material diffuse, thus obscuring the trends.. The purpose of focusing and channeling the material by controlled display of interest is to penetrate the defenses and to enable the patient to produce material which is charged.

4. Principle of Minimal Activity

The physician attempts to attain the intermediate goals by the use of appropriate verbal and nonverbal activity. The degree of activity by the doctor can be adapted selectively and sensitively as a therapeutic tool in the areas of the doctor-patient relation, of the production of material, and of interpretation. In insight therapy in the neuroses, we have found it rewarding to use minimal activity whenever possible. This does not mean *no* activity on the physician's part. Too little activity may be frustrating and serve merely to increase the patient's tension. It means that the doctor's activity, whether in probing for material, in prompting, or in management, is in general to be kept as low as is consistent with the attainment of the therapeutic plans and goals. This principle implies that greater activity is used only after the procedures of low activity have been exhausted. It is only when the patient does not respond that the doctor purposely becomes more active, while recognizing the complications that he may thereby introduce.

There are several reasons why minimal activity is a useful technical procedure in insight therapy. In the first place, minimal activity tends in the neuroses to reduce the random participation of the doctor. Random, uncontrolled activity by the doctor tends to steer the doctor-patient relationship into patterns that resemble a nonprofessional social contact rather than the type of doctor-patient relation that is most effective in this form of therapy. Minimal activity on the doctor's part allows the patient to project his own pattern into the physician-patient relationship, which thus more closely mirrors the patient's mode of personal interaction. This in turn helps the doctor make a clearer diagnosis. Furthermore, it is our experience that minimal activity on the doctor's part allows the patient to talk more freely in meaningful areas. Minimal activity tends also to reduce complications in management and a persistent dependency on the doctor. The inexperienced therapist most often falls into the error of ineffectual overactivity. This is particularly likely to occur when he is at a loss as to what to do, and results in too much advice, too much interpretation, and too much participation.

Procedures in Interviewing

The procedures used in aiding the patient to communicate are both nonverbal and verbal. The nonverbal procedures available to the doctor include facial expressions, nodding, glances, gestures, postural changes, vocal inflection, and intonation. These nonverbal aspects of the doctor's behavior are constantly affecting the patient. They carry a meaning that may reinforce, neutralize, and even outweigh the spoken word. Skill is needed to harmonize the nonverbal with the verbal procedures. There is a need for an activity scale in terms of nonverbal behavior, which at present is not available. We are presenting a scale of verbal procedures arranged in the order of increasing activity: as low, moderate, and marked activity. The form in which the procedures are outlined follows the instructions given to our students and resident staff. This scale is being used for vis-a-vis interviews in insight therapy.

Methods for Low Activity (Fig. 3).—

SCALE OF VERBAL ACTIVITY FOCUSING ON PATIENT'S MATERIAL

Low Activity

1. Articulate Syllables—with Rising Vocal Inflection
2. Repetition of Patient's Last Word
3. Elaboration of Last Word with Incomplete Statement
4. Mild Command
5. General and Specific Questions Aimed at Topic

Fig. 3.

These are the safe methods, and should be mastered first; material so obtained gives a clear picture of the association processes, relatively free from suggestion. Use these methods first and repeatedly. Don't give up in a hurry. Retreat into greater activity only

as a last resort if you fail to obtain material. Avoid taking over the interview; let the patient do the talking.

I. Let the patient browse.

A. Begin by a general question which cannot be answered by yes or no. Avoid leading questions which suggest the answer. Use such questions as "How are things going?" "How do you feel?" "What's been happening?" "What are you thinking about?" "What's going on in your head?"

B. When the patient begins to talk, don't interrupt, allow him to go on. If he hesitates or stops talking, pause for a few seconds or longer and give him a chance to continue. If the silence persists, introduce another general nonleading question as mentioned above.

II. Avoid irrelevant topics.

If the patient talks about topics that do not further your goal, show no interest in the material; take no leads; ask no questions. If necessary, introduce another general question.

III. Focus interest on topics that further your goal.

As soon as the patient mentions a word or a topic related to your goal, focus his attention by one or more of the following devices. You are trying to indicate: "Go ahead. We're interested." Try first the less active of these procedures:

A. Nonverbal activity: Look up; show interest by postural change, facial expression, nodding, intonation, and gestures. If a glance will do, say no more.

B. Verbal activity (Fig. 3):

1. Articulate syllables, use sounds, conversational grunts, and exclamations such as "ah . . . ." "uh huh . . . ." "hmm . . .?" "so . . . ." "well . . . ." "really?" "but . . . ." "and. . . . ." If a simple syllable will do, say no more. Reinforce the inflection with an encouraging look; let your voice carry along. Avoid an air of finality.

2. Repetition of last word. If the patient stops or heads away from the significant topic, repeat patient's last word or phrase bearing on the topic. Say it with a rising inflection as though you were asking a question: "upset?" "blue?" "your heart?"

3. Elaboration of last word. If this fails, elaborate this last word or phrase with an incomplete statement "you said . . . .?" "you said you were . . . .?" "you mentioned pain . . . .?"

4. Mild command. If a patient persists in avoiding topics, be slightly more explicit and use a mild command: "Please tell me more about this." "Let's hear more about this."

5. Questions aimed at topic: If this exhortation fails, ask a *general* question about this topic which cannot be answered by a simple yes or no. "What did you say about your headache?" "What do you mean?" "What do you mean by nervous?" If a general question suffices, do not make it specific.

6. In some cases if these indirect procedures fail, you may have to resort to a direct question aimed at the pertinent topic, such as "In what part of your head do you feel pain?" "What was the feeling in the dream?"

If the patient shows overwhelming affect, you may drop the topic for the time being and introduce another nonleading question as under I. above, keeping alert for the charged topic later in the same interview or in a subsequent interview.

Methods for Moderate Activity (Fig. 4).—

SCALE OF VERBAL ACTIVITY

Moderate Activity

1. For Focusing Directly on Material
   - A. Repetition of Patient's Statements
     1. With Special Emphasis
     2. With Rearrangement
     3. With Juxtaposition
   - B. Descriptive, Elaborating, Summarizing Statements
   - C. Direct Questions as to Associations
2. For Focusing on Difficulties in Communicating
   - A. Questions Relating to the Difficulty in Talking
   - B. Mild Encouragement to Talk
   - C. More Active Encouragement

Fig. 4.

The methods to be described under this heading are reasonably safe for use in goal-directed therapy. They may, however, introduce more artifacts due to suggestion than the less active methods. These methods tend to shift the initiative for activity from the patient to the doctor. They bank more heavily on the relationship, and may lead the

patient into a role of greater dependency. Avoid overdoing them, and always be ready to discard them for the less active methods as soon as you can.

Moderate activity is indicated to focus attention on a topic about which the patient has difficulty in talking. These methods approach the topic more directly. They also attempt to remove resistance by getting the patient to discuss the ideas and feelings which come into his mind when he tries to talk about difficult topics. They emphasize the desire of the doctor to hear about the topic and make use of mild suggestions, encouragement, and mild commands to talk.

I. Procedures for focusing directly on the material.

A. Repetition of the patient's statements: This is done by repeating the statements which we should like to have the patient elaborate. The patient's statements may be simply repeated by the doctor, or may be arranged in special sequence which indicates the temporal or other relationship of the statements. Often the emphasis is conveyed by juxtaposition of the patient's remarks.

B. Summarizing statements by the doctor: The doctor discusses and elaborates the material of the patient by the use of descriptive statements, explanations, and elaborations. He may summarize the patient's material.

C. Direct questions as to the patient's associations: In broaching direct questions, whether of a general or specific nature, attempt to reach the patient by more active signs of interest or by some introductory phrases. For example: "I am very much interested in what you are thinking about. Perhaps you could tell me what's going on in your mind?" "You know it would really help us in working things through if you could tell me what comes into your mind in connection with your feeling of pain."

II. Methods for focusing on difficulties in communicating with the doctor:

A. Questions relating to the difficulty in talking: Attempt to get the patient's associations to similar difficulties in talking in the present or past. "Have you ever had similar difficulties in talking?" "Tell me about other times you've felt the way you feel now." "Can you think back on any other times you've found it hard to discuss your experiences?" Attempt to get the patient's reasons for not talking: "I wonder why you hesitate to talk about this?" "Could you tell me just why it is hard to talk about this?" "I have been thinking about your reasons for not talking. Maybe you can tell me something about them."

B. Mild encouragement to talk: Encourage the patient, and indicate that you know it is hard for him to talk. "I know it is not easy to talk about this." "It must be hard to talk about this—just try and go ahead. Just try to start; it may then go along more easily."

C. More active encouragement: Emphasize your desire and interest in helping. Encourage by becoming more personal. "I really wish you could tell me about this; it might be of help."

Methods Using Marked Activity (Fig. 5).—These methods are to be used with caution in insight therapy in the psychoneuroses. The temptation to use them is great, especially with patients who do not communicate readily. When successful, these methods tend to emphasize the doctor's omnipotence and magic powers. When unsuccessful, they may seriously strain the doctor-patient relationship and give the patient feelings of guilt and inadequacy. When used indiscriminately, they make the material diffuse.

SCALE OF VERBAL ACTIVITY FOCUSING ON PATIENT'S MATERIAL

MARKED ACTIVITY

1. PROMPTING—BY SUGGESTED REASONS FOR RETICENCE
2. PROVOCATIVE AND DRAMATIC INTERPRETATIONS BASED ON PHYSICIAN'S GUESS OR HUNCH
3. PROVOKING AN AFFECTIVE REACTION
   - A. RAPID PROBING
   - B. FOCUSING ON TRANSFERENCE MATERIAL
   - C. FORCING MATERIAL
   - D. DISPLAY OF DISTURBING AFFECT BY PHYSICIAN
4. ACTIVE PARTICIPATION
   - A. ACTIVE REASSURANCE
   - B. SHARING EXPERIENCE
   - C. GRATIFYING PATIENT'S DEMANDS
   - D. SHIFT TOWARD SOCIAL RELATIONSHIP

FIG. 5.

The purpose of these procedures is to shift the doctor-patient relationship so that the patient's barriers against producing pertinent material will be broken down. These procedures are active and are often based on little material produced by the patient. The doctor makes use of his experience with similar patients and his hunches based on the acute observation of subtleties occurring in the interview. The hunch as a resultant or telescoping of a rapid chain of acute psychological or clinical perceptions can be a valuable short cut and adjunct in diagnosis, and in treatment it may be used as a working hypothesis. It has value as a guide post for avoiding the more labored paths of obtaining the material. The danger occurs when the pleasure of the hunch supplants its function as a guide and obscures the actual material produced by the patient. The hunch is very valuable when checked by the material—as in the hands of a wise and skillful therapist.

I. Prompting: By suggesting reasons for reticence: Mention your impressions as to the reasons why the patient is not talking. "I wonder if the reason you are not talking is because you feel I can't help you." "The reason you are not talking is because it'll make you feel guilty—you will have later regrets."

II. Provocative interpretations: Give early and dramatic interpretations of the material. These are based on the general experience and information of the doctor, or upon the doctor's appraisal of the mechanisms and unconscious factors determining the resistance.

III. Provoking affective reaction: Provoke an affective reaction, suddenly shifting the doctor-patient relationship. This is done by rapid probing, focusing the material on the transference relationship, by forcing the patient, and by the display of affect on the part of the therapist. The danger in these procedures is that it is difficult to control them and to predict their effectiveness. The patient may react with overwhelming affect, which may threaten or undermine the therapeutic relationship.

IV. More active participation of the doctor in the interview: In these procedures, the doctor actively reassures the patient; he shares experiences with the patient; he gratifies the patient's demands; he allows the professional relationship to shift toward a social relationship.

We have attempted to summarize some of the principles and procedures used in interviewing in insight therapy in the psychoneuroses. The procedures described in some detail deal mainly with the problem of helping the patient to communicate in meaningful areas. These procedures are presented as guides rather than laws. They are as yet empirical, but they are planned, consistent, and teachable. We are formulating comparable procedures for the other elements involved in insight therapy, including methods for developing, using, and resolving the doctor-patient relation, methods of interpretation and management.

Progress in psychotherapy can, we feel, be made by the use of definite procedures evaluated in terms of the goals they are designed to attain. It is our hope that these studies may stimulate other workers to formulate their experiences with various procedures in psychotherapy. Beginning at first empirically, these coordinated efforts may result in a sound body of knowledge.

THE PSYCHIATRIC SOCIAL WORKER FUNCTIONING AT INTAKE IN A COMMUNITY CLINIC FOR ADULTS [1]

MYRON J. ROCKMORE [2] AND MARION E. KENWORTHY, M.D.[3]
New York, N. Y.

The pressing problem of equating available psychiatric treatment services with the increased demand which has resulted from stimulated public interest presents a dilemma, the resolution of which may hold the future of psychiatry. The release of reams of material for popular consumption via radio, motion pictures, and publications has created an opportunity not without considerable danger. The opportunity: spreading sound mental hygiene principles to a wider public participation eager for help; the danger: being found wanting in meeting this expressed need. The implications of failure to provide this help for those who are stimulated to find it are as obvious as the responsibility of psychiatry to rise to the opportunity to take an increasingly active rôle in preventive medicine.

In removing the barriers of what had heretofore been accepted as the dead-end street of state hospital commitment, we have come to the open road of the shock therapies, the drug therapies, and the rebirth of hypnosis therapy. These, and other methods which hold the promise of rapid recovery, may encourage a public attitude that can result in developing resistances to psychiatry which may take years to be overcome, since in the public imagination psychiatric treatment is already beginning to acquire a magical quality. Psychiatry is not unaware of this double-edged blade and is making efforts to translate this awareness into community psychiatric services. From such a vantage point, there is the possibility of a direct relationship of psychiatry with individuals who have emotional problems for which they seek treatment. Where psychiatry and its related professions meet the public, the reality possibilities of treatment can best be interpreted. The interpretation of the objectives and limitations of treatment and the ability of the patient to participate in planning for such community care will be the foundation on which a sound public attitude can be constructed.

For an individual to see a general medical practitioner involves a decision which at best is complicated. When there is a hypochondriacal element to the illness or if there is obvious need and collateral effort in calling a physician by interested or concerned relatives and friends, an immediate basis exists for the beginning of a treatment relationship. At least as often, there is the tendency to avoid seeking medical help, especially if psychiatric help is needed. The accessibility of medical services, financial ability to afford them, environmental pressures to continue on one's job, and the subtle implications of being a patient are some of the considerations which determine seeking medical assistance. This only exemplifies some of the manifest content which may be involved in seeing a doctor, and, of course does not give sufficient weight to the hopes, fears, and wishes which may be latently involved. When one seeks psychiatric help, these latent, shadowy feelings are transposed into the manifest field. The direct concern which an emotional problem brings when it is recognized as such is considerable. There are usually no convenient home remedies, and more often than not there is little solace in the attitudes of associates who have no basis for understanding what appears to be an irrational feeling. How can one explain that he is unable to go beyond the ninth floor in an elevator, that he has difficulty in swallowing food at the family table, or that he cannot entertain the idea of marriage? These are relatively simple examples of problems which do not necessarily become socially completely paralyzing or known. However, they may cause untold

[1] Read at the 103d annual meeting of The American Psychiatric Association, New York, N. Y., May 19-23, 1947.

[2] Director, Social Service, Treatment Center, N. Y. Psychoanalytic Institute.

[3] Chairman, Clinic Committee, N. Y. Psychoanalytic Institute.

anguish to the sufferer who sees himself as different from his contemporaries, though they may be harboring equally limiting emotional problems.

It is more probable today than it was a scarce 10 years ago that individuals will seek a solution to their problems in some of the methods which they have heard dramatically presented over the radio, read in magazine stories and novels, or seen in the movies and the theatre. They appear at intake, specifically requesting hypnosis, shock, and other therapies. One need only recall the recent newspaper story of the opening of a nursery for children with behavior disorders to illustrate the overwhelming response evoked when a resource is publicly announced. The recognition of this potential patient group brings with it a considerable measure of responsibility for the psychiatric service which meets ambulatory patients who continue to function in the community.

Such a service was inaugurated by the New York Psychoanalytic Institute in July, 1946. The New York Psychoanalytic Institute, with the cooperation of the New York City Veterans Service Center, established a psychiatric unit which offered treatment based on psychotherapeutic techniques which are psychoanalytically oriented.[4] Staffed by a panel of volunteer psychiatrists and administered by a psychiatric social worker, this service was made available to those in the community who had served in the armed forces, but who were not authorized to receive psychiatric care through federal resources.[5] This delineation is important to recognize, since it can be established as a sound working principle that, unless psychiatric services relate to other community resources in a constructive, carefully conceived manner, then even scarce and badly needed services will be duplicated and overlapping. In situations where the individual is eligible for authorization, he is either helped to effect such status or sustained until authorization is forthcoming. The guiding purpose of the service is to help individuals with emotional problems to achieve a more satisfactory community adjustment.

In the intake interview with the psychiatric social worker, the prospective patient finds himself considering the services of a psychiatrist. Especially if he has not seen a psychiatrist before, it is undoubtedly a momentous step for him to take. Over and over again is repeated the picture of a person groping for a solution to an emotionally complicated problem, hoping it will abate or dissolve, only to find the insistence and the intrusion of unproductive energy-building tension with the final result of an admission that, "I need help. I thought I could reason it out, but I seem to be on the wrong road." Comments in nugget-like proportions reveal such gems of interpretive possibilities as, "I could imagine this happening to someone else, but it's tough to take when it's me."

When the realization dawns that the problem is within one's own personality, it is accepted that a treatment potential is in the making. However, the utilization of that potential, once it is crystallized, must be handled with the delicacy that differentiates the professional from the dilettante. If the person who is aware he needs help makes the effort to get it and is fortunate enough to reach a resource where help is possible, there are still cautions and safeguards to be employed which will preserve this treatment potential.

The major emphasis of the intake interview should revolve around the individual's need and desire for treatment, and the ability of the service to meet this need. This formulation presumes that the person who initiates a request for psychiatric help in the community is not only emotionally ill to the degree that he recognizes that he needs such attention, but also usually serves notice that he has sufficient personality health to take the necessary steps which he hopes will bring him results. Therefore, it becomes necessary to approach this interview with the consideration due a prospective patient who has an emotional problem, while maintaining a

[4] Psychoanalysis is not yet offered, but this service is the first step in a program to bring psychoanalysis as well as a diagnostic and consultative service within the reach of community resources and the general public.

[5] The federal government assumes responsibility for the care and treatment of veterans with neuropsychiatric conditions through the Veterans Administration, when it has been adjudicated that these conditions are service-connected or service-aggravated.

respect for the healthy aspects of the personality which are not impaired for dealing with reality problems. If the field of reality in which the individual is capable of functioning is so narrowed that the reality aspects of entering upon a treatment relationship cannot be discussed, then there is a *prima facie* evidence that he is too sick to be treated in the community. In such cases the discharge of a professional responsibility demands that every effort be made to secure disposition to a more circumscribed treatment situation.

The father of two children wandered in asking to see a doctor. He said that he was "a nervous wreck—I can't eat or sleep—I'm making my wife and children nervous." He said that he had left home two days previously because he had not wanted to worry his family by his behavior. He had not been in touch with them during the interval, and had spent his time "walking around." He explained that he "cannot seem to think of anything—while walking around I feel like jumping in front of a subway." He had been feeling bad for about one year, and, although he had seen a physician about a month previously, he did not feel any better.

The man's speech was labored and all but inaudible. He said he hoped that he could get help from a doctor, and when a hospital was suggested, he nodded in assent. Hospitalization was arranged without delay with care to maintain the patient under observation during the procedure. The family was immediately notified, and were very much relieved to know of his whereabouts.

Without laboring the drama inherent in this situation, a very brief interview resulted in help to an individual and his family. In one brief statement is revealed the irrationality of an individual's behavior, and his need to have responsibility assumed for him. It should be noted that although a decision had already been made by the psychiatric social worker, additional pains were taken to permit confirmation and concurrence by the patient. Implicit in the decision is the immediate need of medically qualified supervision and the inclusion of a professional responsibility for the individual that extends beyond the limitations of the psychiatric service to the mental and physical health of the community.

If the possibility of discussing what is involved in psychiatric treatment on a reality basis is accepted as a principle, then the participation of the patient in arriving at a decision to see a psychiatrist is assured.[6] The process starts with a discussion of the problem for which help is sought. It may be a simple statement like "I can't sleep," "I worry when there isn't any reason for it," "I'm irritable." When this beginning is made, sometimes after a short introductory statement by the psychiatric social worker as to the purpose for the interview, it is necessary to maintain a clear focus to keep within the boundaries of the particular psychiatric setting. The psychiatric social worker need only have sufficient information to make a decision to offer an appointment with a psychiatrist or to arrange for an appointment with another community resource. The safest method, where possible, is to limit the interview content at the outset to an account of the problem for which help is being sought. This may have to be done with an explanation, since many individuals, having made the decision to seek help after much introspection and some reading, express their anxiety by offering to give their life story at the outset. Permissiveness of this nature, should the psychiatric social worker fall into such an error, can result in a negative preparation for the meeting with the psychiatrist. The dangers of this practice are frequently overlooked through the misapplication of the skill of the psychiatric social worker in obtaining a social history at intake, and the misapplication of the cathartic effect of "talking it out" as a method of reducing anxiety. A social history should be a social work service to psychiatry as a by-product of a case work relationship with a patient or his family; "talking it out" has lasting therapeutic value only when integrated with a total psychiatric treatment plan. Losing this focus at intake can result in regenerating anxiety, engendering resistance to the potential therapeutic relationship with the psychiatrist, or even having symptoms subside to the degree that the patient does not meet with the psychiatrist.

A young accountant wanted to see a psychiatrist because he had difficulty holding his food down on certain occasions after eating. He explained that

[6] This statement rests on over 400 intake interviews in which every individual for whom an appointment was made with a psychiatrist met with the psychiatrist for the initial interview.

after eating he would have a pain in the stomach which was followed by vomiting. This also happened on other occasions not associated with his mealtime. He noticed that this did not usually occur when he was in the company of his male friends, but did happen when he was out with a girl friend. They were leaving a restaurant when he became nauseous. He asked her to talk to him in an effort to divert his attention. However, the pain became more intense, and he vomited. He described this problem as being "mental." He differentiated this incident from an experience a few months previously when he awoke during the night with "cramps and grumbling in my stomach." This, he felt, was "physical," and accordingly he saw a physician who prescribed for him and he was relieved of his symptoms.

Discussion at the intake interview centered around the need to have a careful organic work-up before a psychiatrist could proceed with any assurance concerning what was involved. The patient's ability to distinguish between an emotional involvement and an organic disturbance, faulty though it might be, was sufficient for him to accept referral to a G. I. clinic as preliminary preparation for his seeing a psychiatrist. He was "impressed by the thoroughness" of the approach and returned to keep his first appointment with the psychiatrist almost two months later.

In this particular case, the emotional problem is not further discussed at intake, and the patient's relationship with the psychiatric service is continued on the basis of a reality plan. The integration of psychiatry with internal medicine and a careful consideration of factors contingent to his problems inspired confidence in the patient and prepared him for the psychotherapeutic relationship. The participation of the patient in this plan was of the utmost importance. If he had not been ready to accept this referral, or had not made the distinction between the "physical" and "mental" nature of his symptoms, an alternative plan would probably have resulted. The reality plan must of necessity be related to the manner in which the symptom interferes with the patient's ability to function. For example, it would have been unwise to consummate the same plan with a person who had undue difficulty in regard to the physical examination procedures. This technique of the psychiatric social worker in maintaining the focus of the intake interview demands a clarity in understanding the purpose of the interview and the objective of the relationship. The purpose of the interview is to help the individual with an emotional problem to get the assistance which he requires and wants. Too often are individuals advised to "see a psychiatrist," either by allegedly interested parties, by those who do not realize the degree of anxiety which might be stirred up by such a statement, or by others who have no appreciation of how difficult it is to get psychiatric time. It should be remembered that, though personality pathology may be evident, the reality factors must be reconciled with possibilities for therapy.

A salesman came to intake seeking a psychiatric appointment at the insistence of his wife. He explained that she said that if he were to do this there might be more of a possibility of their remaining together. They had been separated on and off for several months after a crisis which she had precipitated. She had urged him to see a psychiatrist, but he had put it off. She felt that he was too dependent on her, and thought that their personalities did not complement one another. She also planned to seek psychiatric help.

He explained that they had been married for almost 4 years. His wife had had ambition for a career, and felt that the marriage had interfered with her plans. He was content to sit home with her at night "with a pipe and a glass of beer," but since she last left him he found that he had nothing to occupy his time, and he thought of his personal problems. He commented that he "would be satisfied if I had her—I lost the only thing that really matters. But she isn't satisfied with me. She is more neurotic than I am, although she doesn't think so." He said he would feel no need for treatment if it weren't for his wife's insistence. They saw one another on "dates" and he was concerned about her present living arrangements and employment. He was hopeful that she would return to him as she had a short time before. He felt that the step he was taking to see a psychiatrist would be an inducement to the reconciliation.

The services of a family case work agency were discussed with him. He had never had occasion to be in touch with such a service and was unware of the possibilities it offered. An appointment was arranged for him to discuss his problem further with this community resource. It was subsequently learned that a relationship was developed between this client and the agency which resulted in his being sustained through his wife's eventual divorce proceedings, and that he ultimately went into treatment with a private psychiatrist. At the point where he was ready to accept his problems as an emotional component of his own personality, it was possible for him to accept the need for psychiatric treatment. Had he been unaccepting of the referral to the family agency in an attempt to work out the problem of his marital relationship on a conscious level, it is safe to predict that the meeting with a psychiatrist at that point would have been severely complicated. When the reality of his tenuous marital relationship was decided, he could accept the need for psychiatric treatment as at least consciously

motivated by his own desire. In this illustration is also seen a use of an awareness of timing which may have an important effect on the eventual therapeutic result. The prospective patient in his first meeting with a psychiatric service did not find himself threatened further, and was met with a discussion of the problem which concerned him primarily, *i.e.*, the marital relationship, not his immediate need for psychiatric treatment.

The discussion of the individual's problem at intake can be of inestimable value to the psychiatrist as well as the prospective patient. While it gives the individual an opportunity to consider his problem and approach the practical aspects of entering upon psychiatric treatment, the content of the interview, when presented to the psychiatrist by the psychiatric social worker, affords an unusual opportunity in starting the treatment relationship. The recording of the intake interview in pointing up the problem, the development of it, and the individual's concern, can give a picture of the interrelated factors which resulted in the request for help, as well as what might be an acceptable solution. It is of help in bridging the gap from the intake interview to the psychiatric interview to inform the patient that this material will be passed on, so that the patient knows that the psychiatrist will already have had some familiarity with the situation before the first appointment. The symptom picture, especially if presented in such dynamic terms, can offer both diagnostic and therapeutic leads that will result in a more effective approach by the psychiatrist, who meets a patient well prepared for the interview. This likewise takes a burden off the treatment relationship which causes inevitable delay in getting to the points at issue. Even in cases where severe pathology or a malignant emotional process is at work, the danger signs can be made apparent in a terse recording, and will give the psychiatrist an orientation to his patient which might otherwise take him considerable time to achieve. The possibility of arriving at tentative treatment objectives is also implicit in these recorded observations of the psychiatric social worker.

A 24-year-old wanted help in arriving at a decision. He had discussed his dilemma with friends, relatives, and a vocational guidance agency. However, he felt that they hadn't critically analyzed his problem, and he thought that perhaps a psychiatrist could help him because the more he thought about it, the more he went "around in circles."

He was interested in entering the foreign service of the State Department, and had a choice of three ways of doing this. He was accepted at law school for the term which was 2 weeks away, but this course would take 3 years. The preparation would be good background for other pursuits, as well as preparing him for diplomatic work, and he could simultaneously follow his interest in government. He was also accepted at a well-known school of political science where he could get a Master's degree and direct preparation for the civil service examination. The third choice was to go to the Sorbonne for 6 months under the G. I. Bill. This would indirectly prepare him with another language which would also come in handy for foreign work.

This indecision started shortly after his return from the service 7 months previously. To fill in, he avoided a resolution of his problem by taking graduate courses in English as a "stop-gap." He had become interested in this subject while attending an army university which was set up in Europe after the cessation of hostilities. However, he was now sure that there was no point in continuing with this subject, and the deadline of the new semester made it urgent that he reach a decision. Before the war he knew what he wanted to do. He had been interested in government as an undergraduate and had planned to enter law school. His father, who was an attorney, died about that time and he entered the Army. He said that before his service he "knew where I stood," but when he went into the Army, "I declared a holiday on thinking." He commanded a combat unit in France and Germany, and felt competent to make the necessary command decisions. When hostilities ceased, he afforded himself the opportunity to go to the army university mentioned, where he became interested in English literature.

This man saw a psychiatrist for one interview and made the decision to enter law school. The focal point of the decision was a discussion of his resistance to the move he really wanted to make and planned on making because of his unwillingness to feel he was simply following his mother's wishes if he took this step. Although it would be necessary to have the psychiatrist present his material for a full understanding of what took place, some conjecture is possible. The intake interview pointed up the reality problem which was made acute by the approaching deadline. It gave a picture of an individual who had performed in difficult situations with considerable personality strength. There was a developmental presentation of the problem which made it unlikely that the indecision was of an obsessional nature. This factor undoubtedly entered into the psychiatrist's differential diagnosis. The father's death and the sub-

sequent change of plan, although mentioned in the passing account, gave the psychiatrist a valuable lead, despite the fact that it was not further discussed in the intake interview. The absence of any mention of the mother in the discussion of the problem is striking, in view of the decision arrived at in the psychiatric interview.

It cannot be too strongly emphasized that, in outpatient psychiatric treatment, the patient should be allowed to take the lead to treatment objectives. This is particularly true where the service does not attempt major personality change, but seeks to give assistance within limited areas which will help individuals in their adjustment to community pressures and personal problems. If this is done at the outset, the stage is set to increase the independent aspects of the individual's personality and avoid a chronic dependent relation with the service. This will usually hold true except where the psychiatric service is prepared to offer extensive treatment which will permit of a therapy of sufficient duration and intensity to resolve basic personality conflict. Where such treatment is offered, it will be possible to allow for the period of dependency necessary to reconcile the pathogenic conflict and rebuild the confidence required to meet continuing problems without continued psychiatric help. If this differentiation is not made, the intake of a community psychiatric service can overflow within a short time.

The psychiatric social worker at intake can be very helpful in this objective. By his approach to the individual's problem, he can set the tone of the entire service. Since the discussion is concerned with the conscious aspects of the patient's problem and an interpretation of the service, it is possible and desirable to ask what the patient would wish as a result of his interview with the psychiatrist. This question has brought unusual responses. It has revealed attitudes toward and an understanding of psychiatry, afforded material which reflects the needs of the personality involved; it has given limited objectives to the therapeutic relationship; and it has fixed some measure of responsibility for the relationship within the patient. At the point where this question is asked, it should already be clear that the discussion of the problem has proceeded to the stage where the individual understands that he will be given an appointment with a psychiatrist. Some examples of this technique are of interest.

A college student with a complexity of internalized problems of which he was aware said, "I would like to see a psychiatrist for reassurance that things aren't as bad as they seem to be—that other people have similar problems, that the things I think are normal, and to help me learn that life is like it is and I have to live with it." From this statement alone, one might be inclined to predict a hopeful result, even without an idea of the problem. There is a realistic approach to psychiatry, and some understanding of a need for the emotional acceptance of what has been intellectually verbalized. Another, a department store employee, expressed himself in a somewhat similar vein. He said that "a psychiatrist can probe into what's making me this way, and show me how to help my self. He won't be able to change me radically, but he will be able to help me make better use of my abilities and I'll be able to live with people better." In both of these situations we see evidence of personality strength and an expression of a need for help, but with the recognition that the patient has responsibility for himself and will be the determining factor in the outcome of the therapy. An advertising copy-writer said he had a "need to talk with someone I don't know—I have a deep feeling of hesitation in talking to anyone about this problem. I feel I'd better do something because this is something I'm going to have to solve myself but a psychiatrist may be able to point out something that will help me."

An extension of this same attitude is seen in cases where the patient clearly ascribes a rôle to the psychiatrist. A secretary who had left successive jobs felt that "if I could talk to a psychiatrist, maybe he could give me some good advice—he might find some reason for my acting this way, and maybe he could recommend something." A young attorney thought that a psychiatrist "might be able to point out two or three things I can work on." There is a grading of appreciation of the rôle of the psychiatrist here, but there is still strong evidence of an individual who

feels responsible for himself. Contrary statements are seen in the request for considerable responsibility being asked of the psychiatrist. A young man with a sexual problem said he'd "like to have an idea whether I can be helped—it is very hard to break out of a habit on your own—maybe a psychiatrist can give me a push." This emphasis on "push" has been noted a number of times in requests for help—"I lack push—I don't know even whether I want to be cured." A more consciously dependent statement comes from a sign-painter who commented, "I need a push from someone I can lean on—I tend to try to lean on others too much."

The psychiatrist may use such statements to form the basis for a tentative hypothesis concerning the extent of the treatment relationship. In another sense, they can have diagnostic implications, especially when one gets such comments as "Maybe a psychiatrist might be able to delve down and set me right in my thinking—he might come up with some information about myself which I need to know to keep myself out of trouble." This bank teller, it was later learned, was concerned over extramarital desires which were quite conscious, but which were unacceptable to his moral code. This is an obvious illustration, but was particularly valuable in view of the discussion of his presenting problem, which showed itself as difficulty in conforming to rules and regulations at his place of employment. Attitudes are also reflected, as well as informative bits of misinformation concerning psychiatry—as witness a student interested in psychology who wanted "an interpretation to indicate the reasons for this feeling, and what, if anything, I could do about it. We inherit this type of nervous make-up, but it can be controlled and directed to some extent." This type of question at intake clearly reveals the intellectualized individual who will have difficulty at first because of the fact that his feelings are obscured by his conceptual expressions. In response to the query, one patient asked to see a psychiatrist to find out "what kind of a bug or emotional blocking is there which makes some people show potentiality and not realize it?" It should be noted that such a question asked early in the intake interview can stimulate anxiety without purpose. If it were asked by the psychiatrist in the first interview it might have a disturbing effect on the treatment relationship. However, asked by the psychiatric social worker after a discussion of the problem, it can reestablish the patient on a self-directed level. His freedom of choice and worth as an individual is confirmed.

Implicit in the content of this paper has been a sharp differentiation of the rôle of the psychiatric social worker functioning at intake from that of the psychiatrist who assumes responsibility for the psychotherapy, or the psychiatric social worker to whom a measure of the treatment responsibility may be delegated as the case is formulated. The purpose of the interview has been shared with the client; the consideration of his problem has been undertaken with care not to disturb the treatment potential; the resources of the community have been considered as they relate to his problem; the extent of the service has been set forth (especially when such specifics as psychoanalysis are requested); and the decision has been mutually arrived at to have an appointment with the psychiatrist. At this stage, there can frequently appear the question, "How much treatment can I expect?" or "How long does it take to cure this kind of problem?" The psychiatric social worker must clearly retain an understanding of his intake responsibility and explain that this question is one which will become a responsibility of the psychiatrist and may be answered only in the treatment relationship. In so doing, he reaffirms the responsibility of intake, and differentiates it from the treatment relationship and the primary medical responsibility of the psychiatrist.

To function on this perimeter of psychiatry, a psychiatric social worker must have an appreciation of what is involved in the undertaking of psychiatric treatment, both on the part of the prospective patient and the physician. He must recognize that all human problems have emotionally charged components, but that there are community resources which can help with these problems and reduce the tensions so that the individual can continue to function productively in the community. He must see intake as a process which allows for the maximum participation

of the prospective patient. Adopting this basic attitude offers a foundation on which the emotionally ill individual retains and expands his ability to deal with reality problems. The import of this attitude may contain a cornerstone for preventive psychiatry.

Bringing psychiatry out into the community in this way affords a responsibility to the psychiatric social worker that makes his skill in administering social services invaluable both to psychiatry and to the individuals with emotional problems who seek assistance. Through his techniques of interviewing he is able to bring a sense of consideration and respect for the person who is looking for help. With his orientation to community resources he is able to relate the psychiatric service to contiguous and adjunctive community services. By virtue of his familiarity with psychopathology and the techniques of psychotherapy, the psychiatric social worker facilitates the treatment rôle of the psychiatrist. Through his knowledge of human interrelationship and agency function he can help psychiatry meet the people in their own backyard on their own terms.

AN INTENSIVE NEUROPSYCHIATRIC TREATMENT PROGRAM IN A VETERANS HOSPITAL[1]

WILFRED BLOOMBERG, M. D., SAMUEL SILVERMAN, M. D., ANNE G. LEVINGSTON, M. D., AND WILLIAM F. MURPHY, M. D.[2]

INTRODUCTION

Cushing Veterans Administration Hospital at Framingham, Massachusetts, is a 1,000-bed general hospital. The buildings, located about 19 miles from Boston, are the standard pavilion type of army general hospitals. The Veterans Administration took the hospital over from the Army on October 1, 1946, and set it up as a Deans' Committee hospital for the training of residents under the supervision of the Boston medical schools. Admission of patients to the medical and surgical services began immediately. Admission of patients to the neuropsychiatric service began approximately one month later.

The neuropsychiatric service at Cushing is an independent service of equal rank with medicine, surgery, and neurosurgery. Many general hospitals in the past have had psychiatric units, and certainly many hospitals have had neurological sections. Nevertheless, the neuropsychiatric service now operating at Cushing is somewhat unusual in that it comprises so large a proportion of the total number of available beds, the allotment of 300 beds being 30% of the whole bed capacity. Another respect in which the organization of the neuropsychiatric service at Cushing varies from the average is the presence of what we have termed a "Neurosis Center." This is to say that a considerable number of beds are reserved for psychoneurotic patients with such acute panic and anxiety reactions that it is deemed wiser to treat them in the controlled environment of a hospital setting than to attempt outpatient therapy. The purpose of this section of the service is to provide sufficiently intensive over-all treatment to relieve the acute anxiety symptoms, and to produce enough release of tension that the patient may then be followed on an outpatient basis. Such treatment involves minimal interruption of the patient's work and domestic life, and spares the government the expense of prolonged hospitalization.

Because the neuropsychiatric service at Cushing represents the proposed pattern for development of other similar centers throughout the Veterans Administration hospital system, it has seemed worth while to present some of our fundamental principles, and some of our experiences.

The primary purpose of the neuropsychiatric service is, as in all Veterans Administration hospitals, to furnish good medical care and treatment to the veteran patient. We believe that such care can be furnished only by close integration with the medical and surgical services. It is further believed that the quality of medical care is best in an institution which not only achieves coordination among all the services and free inter-play among the various specialties, but which also provides training in all of these specialties. Like all other branches of the hospital, the neuropsychiatric service has an active teaching program. In all the services, this program is under the general supervision of the Deans' Committee, made up of representatives of Boston's three medical schools: Harvard, Tufts, and Boston University.

The neuropsychiatric service at Cushing is divided into several sections. First, there is the section for the treatment of acute psychoses, which offers all modern types of active intervention in acute psychotic problems, with transfer to other institutions of patients requiring continued care. Second is the neurosis center, which is organized primarily for the treatment of acute psychoneurotic anxiety and panic states, and secondarily for other types of psychoneurosis. A third section is the consultation service, which integrates psychiatry with all the other services and brings to bear upon the problems

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From the Neuropsychiatric Service, Cushing Veterans Administration Hospital, Framingham, Massachusetts.

[2] Dr. Joseph Weinreb and Dr. Richard V. Worthington, as members of the staff of the hospital, collaborated and contributed extensively to this paper.

of medicine and surgery and psychiatry the joint functions of all three disciplines. Fourth is a neurological unit, which also includes a consultation service for neurological problems throughout the hospital. In this section a special project for speech retraining of aphasic patients is in operation, and an additional special project for research in epilepsy has been developed. Beyond these, the usual auxiliary services—clinical psychology, psychiatric social work, occupational therapy, and medical rehabilitation—are well staffed, and well integrated with the neuropsychiatric service. The remainder of this paper will describe in greater detail the function and technique of operation of each of the above sections.

Acute Psychosis Unit

The primary aim of the treatment unit for acute psychotic patients is to supply optimal active therapy. Secondarily, the aim is to provide resident training in the diagnosis and care of the psychotic patient.

Ideally such a program would require an optimum physical plant. Wards should be cheerful; personnel should be sufficient in number, of the highest caliber, and genuinely interested in the patient and his problem. Each ward should have enough space for day room and other recreational sections, and an adequate number of single rooms. There should be no overcrowding of patients, and there should be ready transfer of patients who do not belong in such a unit to a more chronic hospital. At Cushing the typical army pavilion construction has resulted in wards with enough light, and with a reasonable amount of outdoor recreation space. However, the day-room recreation space inside each ward is not sufficient, and the wards, while clean and fairly cheerful at the time they were turned over to us, had no furnishings to make them of more than minimal comfort. Window security is obtained by heavy mesh screening, which cuts off more light than built-in screen protection. It is hoped that, in future construction to which Cushing may be moved, a more suitable physical plant will be provided for the whole neuropsychiatric service.

The policy of moving patients who require continued care, or who have not responded to acute treatment methods, to other hospitals has been accepted in principle by the Branch Office of Veterans Administration in this area. However, the current shortage of beds in other hospitals inevitably limits this aspect of the program.

It should also be noted that the over-all personnel problem in the Veterans Administration hospitals has interfered to some degree with the establishment of the contemplated program at Cushing. When more personnel becomes available, it is expected that additional wards will be opened and a better classification of psychotic patients made possible. One, or possibly two, of the wards will be utilized for shock treatment, and the remaining wards will be graded, so that, as improvement occurs, a patient will graduate from the most disturbed to less disturbed areas, and eventually to open wards, for the final treatment period before either complete discharge or trial visit.

In order to achieve good care and treatment of patients and to provide good training of medical personnel, residents should be allotted in the ratio of 1 per 12 beds on the acute locked ward service, and residency vacancies are figured on this basis. Difficulties at the beginning made it necessary to assign from 18 to 20 patients to each resident, but the figure now approximates 12 patients per resident. The doctor-patient relationship is kept on a personal level by having the resident who was assigned to a patient at the time of his admission follow that same patient through all the various stages of his hospitalization.

Our clinical approach to the acute psychoses is a dynamic one, and psychotherapy or the shock therapies, or a combination of both, is the core around which total treatment is built. Our facilities are such that a case load of 20 patients is regularly carried under insulin shock treatment. Lobotomy has also been authorized at Cushing, and has been performed upon a few selected cases. In selecting cases for treatment by electric or insulin shock, or lobotomy, careful consideration is given to the prognostic criteria, and in no instance have we instituted treatment merely to satisfy relatives or our own consciences, or to increase our statistics.

There is in the hospital a well-organized

occupational therapy department and a recreational therapy department with special services, medical and educational rehabilitation, etc. These services are generally available to our locked ward patients as well as to other patients in the hospital, but for the locked ward patients specifically there is also a separate locked ward occupational therapy shop. Here two registered occupational therapists and a manual arts worker are on duty. Eleven 1½ hour sessions are conducted in the shop during the week. Each class accommodates 20 to 25 patients. In addition, two daily 1½ hour periods are conducted on the most disturbed ward. A corresponding amount of time, so arranged as not to conflict with occupational therapy, is allotted to physical training. In occupational therapy and corrective physical retraining, both of which are under the direct supervision of a full-time chief of physical medicine in the hospital, effort is made to correlate the patient's symptoms with the program prescribed for him. As many patients as possible are taken to the gymnasium daily; those who are physically or mentally unable to go to gymnasium are given limited physical instruction, in good weather in the enclosed courtyards adjoining each ward, in bad weather on the wards themselves.

Approved 35-mm. first-run movies, carefully selected for closed ward patients, are shown twice weekly at the Post Theater, and all patients on the locked ward who are able to go to the theater with attendants are taken. Older, but suitable 16- and 8-mm. films are also shown at more frequent intervals on the wards. The Red Cross Grey Ladies and the Orchid Ladies of the American Legion have been extremely helpful in many capacities. Special parties and dances have been organized, both on the wards and in our own recreation room. Patients indicating musical interest are loaned instruments through the Red Cross, and use these under the supervision of the ward personnel and of the Grey Ladies.

Neurosis Unit

The neurosis center represents a departure from the NP service formerly offered by the Veterans Administration. In this unit provision has been made for treatment of cases of the following types: (1) Patients too acutely ill to be handled by the mental hygiene clinics which have been established in the larger cities. Symptomatology in such cases includes acute anxiety attacks, panic reaction, disabling hysterical symptoms and behavior disorders, all needing treatment in a controlled milieu. (2) Patients who live outside the area served by a mental hygiene clinic. (3) Psychoneuroses or psychosomatic disorders referred from the medical, surgical, or neurological services at Cushing.

The basic purpose of the neurosis center is to treat these cases intensively, but the goal differs according to the case. Patients living in large cities which maintain mental hygiene clinics are treated with the aim of reducing their symptoms to the point where they are able to continue therapy as outpatients at such a clinic. In many cases, especially in alcoholics and personality disorders, where there is much acting out, the only practical goal is to provide some pedagogical training and to establish enough insight to make the patient realize that he is mentally ill and can benefit from attending a mental hygiene clinic. Patients coming from places where such clinics are not available are given longer and more intensive treatment, in order to obtain enough improvement to make it possible for them to lead socially useful and productive lives.

In addition to its primary aim of treatment, the neurosis center was designed to be used for the training of psychiatrists, and also for research in psychotherapy. Effective psychotherapy, especially modern dynamic or analytic therapy, entails a great deal more than ability to take a good psychiatric history and facility in administering a ward, and can be learned only from carefully supervised clinical work. Research in psychotherapy is still in its infancy, and it is hoped that the neurosis unit will be a rich field for studies in all varieties of therapy, including short-term or brief therapy, group therapy, hypnotherapy, and narcotherapy.

The ideal training unit of the neurosis center is a senior psychiatrist supervising the work of not more than 3 residents, each of whom is responsible for the care and treatment of not more than 8 to 10 patients. The senior psychiatrist demonstrates the tech-

nique of the therapeutic interview and acts as control therapist for the resident and patient. He discusses with the resident the plan of attack upon his problems, the goal to be set, and the means of achieving it. With the aid of the social service department and such facilities as occupational therapy, vocational and educational rehabilitation departments, the patient can be treated with the hope of returning him to his environment not only better equipped from a psychiatric point of view to deal with the stresses of life, but oriented toward social and economic goals in keeping with his abilities.

In actual practice, each resident had at the beginning to treat 18 to 20 patients. More recently the ratio has approximated 1 to 10. In acute cases, patients are seen daily, and even the less severe cases are seen at least every other day. If the doctor has too large a case load, and the time element interferes with treatment, both patient and therapist may become discouraged. Poorly handled patients are traumatized for therapy at a later date, and their doctors feel dissatisfied, inadequate, and pessimistic. Overloaded doctors also are unable to find time for necessary collateral reading, and fail to integrate theory with practice. Approximately 30% of the patients treated at the neurosis unit have left against medical advice. Although the majority of these cases were acting out, some of them could have been helped a great deal more, had time permitted.

Psychiatric Consultation Unit

The psychiatric consultation service functions in close and personal relationship with the other professional services. Consultation requests are not viewed as requests for "laboratory data" to be automatically filled out and returned, nor are they considered with the purpose merely of making a classification diagnosis or diagnosis by exclusion. Furthermore the patient is not studied through a strictly psychiatric eye-piece. He is considered as a whole, and dynamic rather than descriptive factors are sought for in the psychiatric evaluation. The consultant works in close touch with the medical and surgical residents and staff, exchanging observations and suggestions with them. The goals of each consultation are always individually determined, never by set rule. They take into consideration primarily how much treatment can be afforded the patient from a practical standpoint.

The more difficult problems are handled therapeutically by the psychiatric staff, either by transfer to our service or on the originating ward. Whenever possible, however, treatment is carried on by the medical or surgical resident, who has had the most opportunity to establish rapport with the patient and knows most about him. This is done under the tutorial supervision of senior members of the psychiatric staff. Thus, in addition to the basic purpose of treatment, an important aspect of this consultation service is teaching medical and surgical residents to avoid the usual unilateral approach to their patients and, instead, to consider them from the psychological as well as the physical standpoint. These residents are not instructed pedantically in complicated theory, but effort is made to give them some understanding of the mental mechanisms involved, and some instruction in the techniques of simple supportive psychotherapy. A psychosomatic conference is held biweekly in the hospital, and is attended by the professional staffs and auxiliary services of both the medical and neuropsychiatric services. A medical case with psychosomatic problems is presented, and full discussion from all standpoints is encouraged, particularly on the part of the residents.

The consultation service most frequently sees patients with physical symptomatology referable to the gastrointestinal tract; next in number are patients with cardiovascular, joint or back, and respiratory symptoms. Some skin cases are also seen. In many of these cases the resident's understanding of the relevant psychological mechanisms and superficial supportive and insight therapy resulted in decrease of anxiety and tension, and improvement in physical symptoms. It was felt that the medical or surgical resident had a better grasp of the case as a whole, and that the patient had benefited more than if he had been treated solely from the physical standpoint.

In a relatively small number of cases referred, the diagnosis of no neuropsychiatric disease was made. About ⅓ of the patients seen in consultation were considered to have

primarily psychiatric conditions, and were recommended for transfer to the NP service. This was accomplished in three quarters of these cases; the remaining quarter insisted on signing out of the hospital rather than being transferred. Usually this was because of resistance to psychiatric treatment or because of very pressing home difficulties. Most of the cases transferred were anxiety reactions. A small number of acute psychoses, either schizophrenic panics, acute depressions, or toxic psychoses, which blossomed suddenly on the medical or surgical wards were sent to the locked ward section of the neuropsychiatric service.

Neurological Unit

The neurological unit comprises approximately 65 beds, and there has been a broad variety of general neurological material constantly flowing through the service. Brain tumor, multiple sclerosis, peripheral neuritis, Wilson's disease, Parkinson's disease, and the ordinary gamut of degenerative diseases of the nervous system have been displayed.

The neurological unit includes a special speech retraining section for aphasics. Competent speech therapists are on duty in sufficient numbers, and a well-integrated program is in operation.

The neurological section also deals with a considerable number of epileptics. Some of these are posttraumatic focal epileptics who are eventually destined to go to surgery. During the war, work was carried on at this hospital in the focal removal of discharging areas in posttraumatic epilepsy, first demarcating the focal area by direct electrocorticograph. This work is still continuing here. In addition, plans are under way for the establishment of a general research project in epilepsy. It is expected that approximately 30 beds, with adequately equipped laboratory, will be available for the study of medical nonsurgical epilepsy. An adequate electroencephalographic laboratory serves not only the neurological section but the entire hospital. We have three 4-channel Grass machines.

The neurological section carries out a considerable consultation service throughout the rest of the hospital. As usual in most general hospitals, some of the neurological cases are admitted on the medical service and are treated there. However, the neurological section has the opportunity to see all of these in consultation. Some of them are transferred to us, and some are continued on the medical and other services.

There is a 50-bed neurosurgical service in the hospital which occupies wards adjoining the neurological section. Except for acute neurosurgical emergencies, such as compound fractures of the skull, and moribund patients with high degrees of choked disk and probable brain tumor, all neurological and neurosurgical cases are first admitted to the neurological section for study, those requiring operation being transferred to the neurosurgical section upon completion of observation. There is a close working relationship, and an interchange of residents, between these two services.

Auxiliary Units

It has already been noted that adequate occupational therapy, physiotherapy, vocational and medical rehabilitation departments are available. There is a physical medicine service also, which works closely with us and supervises the above activities in regard to our patients. Recreation is provided by a special services section, and with the collaboration of the Red Cross, the American Legion Ladies Auxiliary, and the USO, and other groups in nearby communities, there is a constant flow of helpful visitors and entertainers through the wards of the hospitals.

We have a very active clinical psychology section, which is a vital part of the neuropsychiatric service. It consists of 3 competent clinical psychologists whose primary function is diagnostic examination of our patients, but who in addition take part in all staff conferences concerning patients, and contribute their point of view on treatment as well as diagnosis. More psychologists would be welcome at Cushing; those already on duty have proved themselves invaluable.

The psychiatric social work department is composed of 3 trained workers, who also attend all clinical conferences, and whose work is closely coordinated with that of the resident and the senior staff. It should be noted that both the psychological and social service departments at this hospital will train students in their special fields. The social

service department already has students at hand, and plans are completed for trainees in psychology.

Residency Training

No report of the work of the neuropsychiatric service at Cushing would be complete without some account of the residency training program. This program is integrated with that of the other hospitals in the New England Area, Branch No. 1, of the Veterans Administration. At our hospital the basic teaching philosophy is that a carefully selected resident will best learn psychiatry by being given personal authority and responsibility for the care and treatment of patients, subject to the tutorial supervision of a more experienced member of the staff or of the attending staff. Board-qualified members of the senior staff are present in approximately the ratio of 1 to each 20 patients. Where this ratio cannot be achieved, the difference is made up by having similarly experienced Board-qualified attending staff members. Residents are available on the locked ward in the ratio of 1 per 12 patients, on the open ward service and on the neurological service in the ratio of 1 to 10 patients. Each senior staff member or attending specialist is responsible for the work of not more than 3, and usually only 2 residents. Attending specialists come in for tutorial ward rounds at intervals of not less than 2 and usually 3 times per week. Ward rounds in psychiatry, with either the attending or the full-time hospital staff, do not consist of brief stops at each bedside, but of careful evaluation of what was said by the patient and by the resident in interviews, what was done, what the plan of treatment is, and how it is being accomplished.

Beyond these tutorial conferences about specific cases, a daily staff conference of the entire department is held. This is a teaching conference, concerned each time with thorough consideration and discussion of one case. The resident presents the case history and findings; the psychologist reports; the social service department reports; the nurse in charge of the patient comments; the occupational therapy and athletic and other departments which have knowledge of the patient make their contribution. The patient is then interviewed, and thereafter the resident formulates the case and a general discussion ensues. The entire orientation of the department is dynamic, and the conferences tend to produce very dynamic discussion. Residents are encouraged to express their opinions, and in general have done so very freely and very fruitfully. Three times each week psychiatric cases are presented at conference, once a week a neurological case; on the remaining day the schedule varies, including 2 joint conferences each month with the medical service on a psychosomatic problem, one a month on a case from the epilepsy or the aphasia sections, and a joint conference once each month with the eye, ear, nose, and throat department on eye-nerve or ear-nerve problems.

Once each week a 2 hour seminar is held with the entire staff. For these, people have been invited from Boston and other places, or from our own staff, to present special research results or special problems in which they are interested. The seminars do not follow a rigid pattern but are planned in response to interests in particular fields expressed by the residents, or to some question which has come up in ward rounds or conference. In general, an approximately 45-minute presentation of the topic is made, with the remaining time spent in free discussion.

Once a week the residents conduct a critical review of the literature in a Journal Club. Residents will also attend, once a week, the course of lectures given by the Metropolitan State Hospital in this area. These will cover didactic exercises in neurology and psychiatry.

When qualified, residents are encouraged to begin training psychoanalysis through the nearby Boston Psychoanalytic Institute. Ideally we should have two full-time training analysts here at the hospital, but at the moment this seems wishful fantasy! However, opportunity is given and time allowed for analysis, if the individual resident can make the necessary arrangements.

While the service is dynamically and analytically oriented, we insist upon an eclectic presentation of the material of psychiatry, with critical evaluation of all tenable hypotheses.

Conclusion

Cushing is a new hospital, and our service is feeling its way by trial and error into its permanent pattern. The material above represents a fair cross section of our present activity. We hope in the future to be able to say more specifically what has been found useful, and what has been abandoned. Not only our psychiatric orientation but our total situation is dynamic. We believe that our organization has a contribution to make to the care and treatment of neuropsychiatric patients. We shall continue to evaluate ourselves and to welcome criticism.

THE CHARACTERISTICS OF THE PSYCHOPATH

HULSEY CASON

The University of Miami, Miami, Florida

The purpose of the present study was to obtain as complete and accurate information as possible on the characteristics of the important and troublesome condition known as psychopathic personality. The results we have secured in this investigation will be of definite value in the understanding and in the diagnosis of this type of personality.

The present study was carried out in the Psychopathic Unit of the Medical Center for Federal Prisoners, Springfield, Missouri. The Medical Center is the prison hospital of the Bureau of Prisons. Male prisoners are transferred to this hospital from the 26 other Federal penal and correctional institutions, (1) for medical reasons, and (2) because they are behavior problems. The Psychopathic Unit is a 304-bed hospital unit designed for the care and study of different kinds of psychopaths.

The data here set forth were collected in conjunction with an 80-item punch card code study of the records of 500 Medical Center inmates who at one time or another had been on the local administrative status of constitutional psychopathic inferiority (C.P.I.), and who had been discharged from the Medical Center. In the 80-item code used, there were 70 single items, 7 double items, and 3 triple items. The data collected were concerned with such diverse topics as family history, general personal data, general social history, personality adjustment, delinquency history, admission data, medical history, work adjustment, discharge data, and F.B.I. follow-up data. Some results were obtained on almost 1,000 of the subitems in the code, and numerous cross calculations were made between the different categories of results.

The 500 subjects studied represent an exceptional assortment of cases of unusual psychiatric interest. Their average age on discharge from the Medical Center was 26.7 years. The average I.Q. was 97, and the average number of grades of formal education was 7.6. About 85% of the subjects were white, and 95% were native born. Fifty-one percent were Protestants, and 14% had no religious preference. About one-fifth had been married. One-third had had some kind of military experience; of those with military experience, 82% had received a discharge other than honorable. The subjects came from all parts of the United States, but seven-tenths were from cities of more than 5,000 population. One-half were transferred to the Medical Center from Institutions of the penitentiary type, and one-third were transferred from reformatories. The most common offense was a violation of the National Motor Vehicle Theft Act. The average length of the current sentence was 4.6 years. The average time served on the current sentence before discharge from the Medical Center was 33.9 months, and the average time spent at the Medical Center was 18.5 months. The results of this punch card code study have been summarized and published jointly with M. J. Pescor, in *Public Health Reports,* 1946, **61**, 557-574.

Procedure

After the coding of each of the 500 subjects we made a detailed record of the following additional types of information which, it may be noted, are not suitable for or adapted to the coding procedure.

(1) *Disease History.*—We began with a fairly complete list of organic medical diseases which sometimes have a definite and detrimental influence on intelligence and personality. Each subject was checked with respect to this list of diseases. The incidence of some of the diseases in the original list—such as deficiency diseases, hookworm disease, tumors, etc.—was not high enough to yield reliable results; but for our purpose, fairly good data were obtained on the following items:

1. None of the list of diseases
2. Chorea
3. Encephalitis
4. Head injury
5. Influenza
6. Malarial fever
7. Meningitis

8. Pneumonia
9. Rheumatic fever
10. Scarlet fever
11. Syphilis
12. Tuberculosis
13. Typhoid fever

In these and the following four sets of items, several items were frequently checked for a single subject. This is a procedure that cannot be followed with the punch card code method.

(2) *Early Family and Social History.*—Each subject was checked against the following items:

1. None of the list of items
2. Partly reared by aunt or uncle
3. Partly reared by grandparent or grandparents.
4. Mother morally loose
5. Father a criminal
6. Degenerate home
7. Emotionally rejected
8. Cruel and brutal treatment
9. Spoiled and pampered
10. Poor early associates.
11. Poor personality adjustment in school
12. Ran away from home

Many of the subjects were checked on more than one of these items.

(3) *Personality Traits and Characteristics.*—Each subject was checked with respect to a fairly long list of personality traits and characteristics. One writer or another has held that each of these characteristics is a valid symptom of the psychopath. The incidence of some of the items was not high enough to give reliable results, but fairly reliable results were obtained on the following items:

1. None of the list of items
2. Deductive rather than inductive
3. Impulsive
4. Paranoid symptom
5. Rigid personality
6. Emotional immaturity
7. Excitable
8. Dull or flat emotionally
9. Organic inferiority
10. Feeling of inferiority
11. Sad, brooding, or depressed
12. Egotism, vanity, and conceit
13. Selfishness
14. Poor conscience
15. Self-assertion
16. Anger
17. Hate
18. Hostile
19. Ruthlessness
20. Vicious
21. Illegal offense against the person
22. Homicidal

(4) *Psychiatric History.*—Each subject was checked with respect to a fairly detailed list of psychiatric symptoms, and statistically reliable results were obtained on the following items:

1. None of the list of items
2. Poor insight
3. Pathological lying
4. Alcoholism
5. Nervous
6. Anxiety symptom
7. Schizoid symptom
8. Emotional instability
9. Self-inflicted wounds
10. Suicidal
11. Manic trends or compulsions

(5) *Psychiatric Diagnoses.*—The most basic and also most important type of information obtained in the present study was a careful diagnosis of each individual. On the basis of the extensive and detailed information available, each subject was checked with respect to the following psychiatric diagnoses:

1. None of the following
2. Personality maladjustment only
3. Psychopath
4. Criminal psychopath
5. Homosexual
6. Psychotic (or schizoid) psychopath
7. Feeble-minded
8. Epileptic
9. Psychotic
10. Psychoneurotic

Subjects were not infrequently checked and classified in more than one of these categories. The number of cases in groups 6-10 above were not large enough to give reliable results, but the results obtained with groups 1-5 were quite reliable. The results for the first four groups of subjects will be described in the present study, and the results on the group of homosexual subjects, which are quite different from the results on psychopaths, will be described in a separate paper.

All these results, as well as the data obtained in the punch card code study, were used in the present investigation, in which we have made a detailed comparison between the traits and characteristics of four different kinds of subjects: (1) control or normal subjects, (2) cases of personality maladjust-

ment, (3) psychopaths, and (4) criminal psychopaths.

(1) *Control Group* (C) ($n=47$).—This group is made up of fairly normal individuals, with an ordinary personal history, normal traits and characteristics, no marked psychiatric symptoms, and a good adjustment and behavior record at the referring and local institutions. This is the best control group to use in evaluating the traits and characteristics of the psychopath.

(2) *Personality Maladjustment* (PM) ($n=102$).—The individuals included in this group have gotten into various kinds of trouble; they sometimes have a considerable history of delinquency; and they are more or less inadequate in their personality organization. They are less normal than the subjects included in the control group, but they do not have enough psychopathic symptoms to be diagnosed as psychopaths. These subjects are intermediate between the preceding control group and the following psychopathic group, and they may be regarded as moderately psychopathic and as a kind of control group. For want of a better name, we shall refer to them as cases of personality maladjustment. These individuals are sometimes referred to as cases of "simple adult maladjustment," but the maladjustments are not simple, and the subjects are not necessarily adults. We have also not used the diagnosis, "psychopathic personality with pathologic emotionality, emotional instability," which places too much emphasis on emotional activities and neglects other aspects of the total personality.

(3) *Psychopaths* (P) ($n=55$).—All the individuals included in this group are clear and obvious cases of psychopathic personality. Since the concept of the psychopath which we employed is being described in a separate paper (in *Amer. J. Orthopsychiat.*), it will not be discussed in detail at the present time. Our concept of the psychopath is closely related to the concepts of primitive drives, antisocial modes of behavior, and the control of primitive antisocial modes of behavior. The psychopath or psychopathic personality may be defined as "a personality reaction type and a functional condition of the individual in which there is a serious lack of ability to control several of the primitive drives and antisocial modes of behavior." Psychopathic behavior is primitive antisocial behavior, and a person may be regarded as a psychopath if he has a serious lack of ability to control several of the primitive antisocial modes of behavior.

(4) *Criminal Psychopaths* (CP) ($n=107$).—In addition to being definitely psychopathic, the subjects included in this group have a confirmed criminal attitude and philosophy, and a considerable criminal record, at least for their ages. These criminal psychopaths are at least as psychopathic as those included in the psychopathic group, but this group includes a larger number of psychopaths of the extreme aggressive type.

These four groups were made up in such a way that the comparisons between the traits and characteristics of the subjects in the different groups would be as clear and as valid as possible. To this end, the following six classes of individuals were excluded from the four comparison groups used in the present study: (A) individuals who were predominantly homosexual; (B) psychopaths who had some psychotic (frequently schizoid) symptoms; (C) individuals who were feeble-minded or of borderline intelligence; (D) epileptics; (E) psychotics; and (F) psychoneurotics. The exclusion of these six classes improves the purity of our groups and greatly increases the accuracy and the meaning of the results relating to the symptoms of the psychopath. The total number of subjects in the individual classes (B) to (F) was not large enough to give reliable results.

Attention may be called to the fact that our original population of 500 subjects probably included a larger number of good cases of psychopaths and excellent cases of extreme, aggressive, criminal psychopaths than have ever been brought together before within the walls of a single institution. All the subjects were Federal prisoners housed in the psychopathic unit of the Medical Center. The control of the inmates and the opportunities for observation and research were such that our results are not limited to persons in penal and institutional situations but also apply to the problems of psychopaths in general, and to psychopaths outside of institutions. The general value and validity of our results are

greatly increased by the fact that the subjects in the control group and in the personality maladjustment group were living in the same institution, in the same unit, and under the same general living conditions as the subjects in the psychopathic and criminal psychopathic groups.

Negative Results

The statistical calculations made in the present study were of two principal kinds: (1) we calculated the percent of subjects in each of the four comparison groups to whom each item applied or for whom each item was true; and (2) we calculated the averages or weighted averages in the case of several quantitative categories. The data obtained in the original punch card code study and many other results were used in comparing the traits and characteristics of the four groups of subjects. Many percentages and averages were calculated and many comparisons were made, but in the present paper we shall limit ourselves to a description of the most important findings. The principal negative results will be described in the present section, and the principal positive results on the characteristics of the psychopath will be described in the section that follows.

The most significant results which are essentially negative in character are summarized in Table 1. These results show that the items listed in the table are not characteristic of psychopaths or criminal psychopaths.

In item 1, for example, the percent of subjects in each group who were of the Nordic "race" are: control group, 64%; personality maladjustment group, 61%; psychopaths, 69%; and criminal psychopaths, 74%. The results obtained on the first six items in the table indicate that the contingency between race and psychopathic traits is poor and irregular.

The results on items 7-12 show that these items of family history are also not characteristic or symptomatic of the psychopath. The incidence of the death of the father (item 7), death of the mother (8), separation or divorce of the parents (9), and unusual like for the mother (10) is about as high in the control and personality maladjustment groups as in the psychopathic and criminal psychopathic groups. The scores for item 11, several homes and reared by various relatives, are approximately the same for the four groups. In calculating the weighted averages for item 12, economic status of parents, the following weights were arbitrarily assigned to the original subitems in the code: well-to-do, +2; comfortable, +1; marginal, −1; and submarginal, −2. The average scores for the control and psychopathic groups are approximately the same.

The average scores for item 13, intelligence quotient, and for item 14, number of grades of formal education, do not show any very reliable differences between the four groups of subjects. However, as far as these results go, the criminal psychopaths seem to have slightly more intelligence and slightly less formal education than the subjects in the three other groups.

It is of some theoretical importance that the results on items 15-30, on the influence of various organic medical conditions on psychopathic traits, are essentially negative. The incidence of a number of these diseases or conditions is higher in the control group than in the psychopathic group, and also higher in the personality maladjustment group than in the criminal psychopathic group. The frequency of other diseases and conditions is approximately the same for the four groups. The incidence of rheumatic fever (item 15) is highest in the control group; the incidence of pneumonia (19) is lowest in the psychopaths; the incidence of gonorrhea (20) is highest in the criminal psychopaths; the incidence of gonorrhea and syphilis (22) is highest in the control group; the incidence of head injury (23) is highest in the criminal psychopaths; and the incidence of organic inferiority (24) is highest in the personality maladjustment group. Results of this kind do not give any evidence that these organic conditions can be regarded as etiological factors in psychopathic personality.

The scores for item 33, married and separated or divorced, are higher for the control group than for the psychopathic group; and the scores for item 32, intact marriage, and for item 34, married two or more times, are approximately the same for the four groups.

TABLE 1

NEGATIVE RESULTS

Items	Groups of subjects			
	C ($n = 47$)	PM ($n = 102$)	P ($n = 55$)	CP ($n = 107$)
Race:				
1. White, Nordic	64%	61%	69%	74%
2. White, Slavic	0%	7%	7%	3%
3. White, Latin	4%	5%	5%	3%
4. White, mixed or other	9%	13%	2%	8%
5. Negro	15%	11%	11%	9%
6. American Indian, or Mexican	4%	4%	4%	3%
Family History:				
7. Death of father	11%	12%	13%	11%
8. Death of mother	6%	11%	5%	3%
9. Separation or divorce of parents	23%	17%	16%	23%
10. Unusual like for mother	13%	14%	9%	13%
11. Several homes, reared by various relatives	11%	7%	13%	13%
12. Average (weighted) economic status of parents	− 0.06	− 0.16	− 0.04	− 0.26
Intelligence and Education:				
13. Average intelligence quotient	99.6	97.5	98.2	100.5
14. Average number of grades of formal education	8.1	8.0	8.0	7.4
History of:				
15. Rheumatic fever	9%	3%	0%	5%
16. Influenza	17%	16%	13%	14%
17. Scarlet fever	11%	8%	11%	5%
18. Malarial fever	4%	6%	5%	2%
19. Pneumonia	21%	17%	5%	21%
20. Gonorrhea	21%	21%	24%	30%
21. Syphilis	4%	8%	7%	6%
22. Gonorrhea and syphilis	11%	7%	4%	7%
23. Head injury	11%	11%	11%	16%
24. Organic inferiority	13%	22%	9%	12%
The Most Important Medical Diagnosis at the Medical Center:				
25. Diseases of the heart or lungs (including tbc.)	6%	6%	2%	4%
26. Syphilis	9%	11%	7%	10%
27. Non-venereal diseases of the genitalia	4%	1%	4%	7%
28. Musculo-skeletal defects	13%	12%	4%	6%
29. Diseases of the eyes	6%	9%	11%	13%
30. Dental defects	32%	28%	31%	28%
Marital History:				
31. Never married	70%	73%	76%	73%
32. Married, intact	4%	7%	4%	5%
33. Married, separated or divorced	13%	10%	5%	9%
34. Married two or more times	6%	6%	5%	7%

The results for items 31-34 on marital history show that these items also are not characteristic of psychopathic personality.

THE CHARACTERISTICS OF THE PSYCHOPATH

The positive results on the characteristics of the psychopath are summarized in Table 2.

The percentage scores for item 1, no irregular or unusual family history, are 19-10-2-5, respectively, for the four groups of subjects. These scores are reliably higher for the control and personality maladjustment groups than for the psychopathic and criminal psychopathic groups. The scores for item 2,

TABLE 2

POSITIVE RESULTS ON THE CHARACTERISTICS OF THE PSYCHOPATH

Items	Groups of subjects				Symptoms in Table 3 which item supports
	C ($n = 47$)	PM ($n = 102$)	P ($n = 55$)	CP ($n = 107$)	
Family History:					
1. No irregular or unusual family history..	19%	10%	2%	5%	A
2. Degenerate home	0%	14%	18%	26%	A
3. Father a criminal.....	4%	8%	13%	17%	A
4. Did not like parents.....	11%	18%	24%	33%	A, D
5. Unusual dislike for father.....	11%	12%	25%	21%	A, D
6. Emotionally rejected during childhood..	15%	26%	31%	44%	A
Childhood History:					
7. Ran away from home.....	36%	44%	64%	62%	A, E
8. Obedient and well-behaved before the age of 16.....	70%	42%	13%	11%	A, B, D, E
9. Headstrong, wilful, and difficult to manage before the age of 16.....	9%	16%	44%	61%	A, B, D, E
10. Poor personality adjustment at school..	28%	22%	58%	55%	A, B, E
11. Poor early associates.....	36%	53%	60%	76%	2
12. Average (weighted) adjustment before the age of 16.....	+ 0.32	− 0.31	− 1.18	− 1.38	A, B, D, E
Traits and Characteristics:					
13. Poor conscience	9%	45%	64%	83%	7
14. Selfishness	0%	7%	15%	28%	B, C
15. No preference for religion.....	6%	12%	16%	30%	B, C
16. None of a list of undesirable personality traits and characteristics.....	21%	9%	0%	0%	A, B, C, D, E
17. Egocentric	11%	30%	64%	77%	9
18. Feeling of inferiority.....	13%	29%	35%	39%	C
19. Deductive rather than inductive.....	2%	15%	65%	77%	10
Psychiatric Symptoms:					
20. Poor insight	9%	18%	36%	55%	11
21. Paranoid tendency	0%	8%	27%	41%	12
22. None of a list of psychiatric symptoms..	34%	18%	9%	5%	C, D, E
Affection:					
23. Prone to anger.....	17%	16%	51%	71%	13
24. Prone to hate.....	4%	5%	38%	53%	14
25. Hostile	4%	18%	62%	78%	15
26. Vicious	0%	3%	25%	36%	B, D, E
27. Ruthless	4%	3%	18%	45%	16
28. Excitable	4%	3%	16%	16%	D, E
29. Emotional immaturity	17%	30%	69%	49%	D, E
30. Emotional instability	32%	49%	60%	67%	D, E
Conation:					
31. Self-assertion	19%	15%	67%	78%	17
32. Impulsive	32%	35%	85%	80%	18
33. Pugnacious	6%	10%	13%	19%	20
Delinquency History:					
34. Illegal offense against the person.....	6%	14%	40%	60%	A, B, D, E
35. Homicidal	0%	1%	7%	21%	A, B, D, E
36. Average age (yrs.) of first arrest.....	19.4	18.2	15.9	15.0	A, B, E
37. Committed to an adult penal institution other than jail on first arrest.....	32%	16%	5%	4%	A, B, E
38. Average length (yrs.) of current sentence	3.83	4.09	4.74	4.87	A, E

TABLE 2—CONTINUED

Items	Groups of subjects				Symptoms in Table 3 which item supports
	C ($n = 47$)	PM ($n = 102$)	P ($n = 55$)	CP ($n = 107$)	
Adjustment at Medical Center:					
39. Average (weighted) work adjustment at Medical Center	+ 0.43	+ 0.06	− 0.40	− 0.64	A, E
40. Average (weighted) dormitory adjustment at Medical Center	+ 0.57	+ 0.17	− 0.22	− 0.40	A, B, D, E
41. Average number of adverse behavior reports per year at Medical Center	0.72	1.05	1.69	1.85	A, B, C, D, E
42. No adverse behavior reports at Medical Center	68%	44%	24%	21%	A, B, C, D, E
43. Average (weighted) seriousness of adverse behavior at Medical Center	0.81	1.52	2.58	3.21	A, B, C, D, E
44. Average (weighted) seriousness of disciplinary action at Medical Center	0.74	1.55	2.45	2.64	A, B, C, D, E

degenerate home, are 0-14-18-26, respectively, for the four groups, showing that the incidence of a degenerate home is much higher in the psychopathic group than in the control group, and also higher in the criminal psychopathic group than in the personality maladjustment group. The results on item 3, father a criminal; item 4, did not like parents; item 5, unusual dislike for father; and item 6, emotionally rejected during childhood, show a distinct difference between the control group and both of the psychopathic groups. Comparing the results for items 1-6 on family history in Table 2 with the results for items 7-12 in Table 1, it is apparent that only a limited number and only certain kinds of items of family history are positively correlated with the symptoms of the psychopath.

The results on childhood history (items 7-12) in Table 2 are quite different for the control and psychopathic groups. The scores for item 8, obedient and well-behaved before the age of 16, are 70-42-13-11, respectively, for the four groups. For item 9, headstrong, wilful, and difficult to manage before the age of 16, the respective scores are 9-16-44-61. In calculating the average weighted adjustment before the age of 16 (item 12), the following weights were assigned to the original subitems in the code: obedient and well-behaved, +1; obedient but in frequent difficulty, −1; and headstrong, wilful and difficult to manage, −2. The four average scores for adjustment before the age of 16 were +0.32, −0.31, −1.18, and −1.38.

The results for items 13-33 on various traits and characteristics show that all these items are symptomatic of psychopathic personality. For several of these items, the differences between the control and psychopathic groups are quite marked. The percentage scores for poor conscience (item 13) are 9-45-64-83; for selfishness (14) 0-7-15-28; for none of a list of undesirable traits and characteristics (16), 21-9-0-0; for egocentric (17), 11-30-64-77; for deductive rather than inductive (19), 2-15-65-77; for paranoid tendency (21), 0-8-27-41; for hostile (25), 4-18-62-78; and for self-assertion (31), 19-15-67-78.

Although items 34-38 on delinquency history and items 39-44 on adjustment at the Medical Center have a somewhat limited meaning and application, they nevertheless give some further positive data on the characteristics of the psychopath. For our groups of subjects, the respective scores for illegal offense against the person (34) are 6-14-40-60; for the average age of first arrest (36), 19.4, 18.2, 15.9, and 15.0; and for committed to an adult penal institution other than jail on first arrest (37), 32-16-5-4.

In calculating the average weighted work adjustment at the Medical Center(39), the following weights were assigned to the original subitems in the code: unemployed, −2; poor, −2; fair, −1; satisfactory, 0; good, +1; and excellent, +2. The average scores for work adjustment(39) are +0.43, +0.06, −0.40, and −0.64. In calculating the average dormitory adjustment(40), the weights

assigned to the subitems in the code were as follows: good, +1; average, 0; and poor, −1. The average scores for dormitory adjustment (40) are +0.57, +0.17, −0.22, and −0.40. In calculating the average seriousness of adverse behavior (43), the weights assigned to the subitems were as follows: minor infractions, 1; homosexual, 2; insolence, 3; fighting, 4; agitating, 5; destructive, 6; and assaultive, 7. The average scores for seriousness of adverse behavior (43) are 0.81, 1.52, 2.58, and 3.21. In calculating the average seriousness of disciplinary action (44), the weights assigned to the subitems were these: reprimand and warning, ½; loss of privileges, 1; segregation, 3; and loss of good-time or new sentence, 7. The average scores for seriousness of disciplinary action (44) are 0.74, 1.55, 2.45, and 2.64.

The positive results in Table 2 which show that certain traits and characteristics are valid symptoms of the psychopath are of several different kinds. An examination of these results will show (1) that some of the results are more positive than others, (2) that two or more items are often related to the same topic, and (3) that there is a considerable amount of overlapping in meaning between some of the items and groups of items. In view of these factors of overlapping and duplication and the relative nature of the results, we have made a further study of all the positive and negative findings, and have given special attention to selecting and phrasing what seem to be the best supported and most useful symptoms of the psychopath. These symptoms, in an improved classification and arrangement, are given in Table 3.

TABLE 3

THE SYMPTOMS OF THE PSYCHOPATH

(A) *History*:

1. Poor emotional environment of early home
2. Poor early associates
3. History of poor behavior
4. History of antisocial conduct

(B) *Morals*:

5. Poor moral sense
6. Poor sense of fairness and justice
7. Poor conscience
8. Not concerned over interests and welfare of other people

TABLE 3—CONTINUED

(C) *Cognition*:

9. Egocentric
10. Deductive rather than inductive
11. Poor insight
12. Paranoid tendency

(D) *Affection*:

13. Prone to anger
14. Prone to hate
15. Hostile
16. Mean or ruthless

(E) *Conation*:

17. Self-assertion
18. Impulsive
19. Anomalous and self-thwarting behavior
20. Threatening or pugnacious

An attempt has been made to phrase each of the symptoms in Table 3 in such a way that there will be as little overlapping in meaning as possible. The symptoms are numbered from 1 to 20, and grouped under five headings (A) to (E).

In the right-hand column of Table 2, we have indicated which of the symptoms or groups of symptoms in Table 3 are supported by the results on each of the items in Table 2. For example, in Table 2, the results on item 1 support the A group of symptoms in Table 3; the results on item 11 in Table 2 support symptom No. 2 in Table 3, etc.

CONCLUDING STATEMENT

In attempting to decide whether or not a given person is a case of psychopathic personality, it is desirable to have in mind a clear concept of the general nature of this condition; but in addition to having a clear concept of psychopathy in mind, a concrete list of symptoms such as we have derived will also be of much practical value. All the symptoms of the psychopath are human and natural, and these symptoms practically coincide with the forms of behavior which the leaders of the great world religions have urged man to attempt to control. One of the most difficult problems of life is to control these primitive antisocial modes of behavior in a fairly decent and satisfactory manner.

In judging the extent to which a given person is a psychopath, account should be taken of the strength and prominence of the symp-

toms, as well as the number of different symptoms. Some psychopaths have all the symptoms in the list, and other psychopaths have a smaller number of symptoms but in a more pronounced form. It will be convenient and practical to diagnose a given individual as a case of psychopathic personality if he has a reasonable number of these symptoms in a fairly pronounced form.

Individuals naturally differ in the number of psychopathic symptoms they present; and the extent to which any person or any kind of behavior is psychopathic also differs in degree. Most people have some psychopathic symptoms, and it would seem that, for a person not to have any of the symptoms of the psychopath even to a slight degree, it would be practically necessary for him to be a saint. The great mass of the population, with their different patterns and groupings of a limited number of symptoms, fall somewhere between the psychopath and the saint.

ELECTROENCEPHALOGRAM IN CASES WITH CORTICAL ATROPHY AND VENTRICULAR DILATATION[1]

SIDNEY LEVIN, M. D., AND MILTON GREENBLATT, M. D., BOSTON, MASS.

Since the introduction of electroencephalography a variety of wave disturbances have been reported for cases of brain atrophy. In 1937, Walter and Wyllie(1) described *delta waves* in the left occiput of a child who had pathological enlargement of the posterior horn of the left ventricle; at operation cortical atrophy was clearly visible. In the same year, Lemere(2) reported the electroencephalographic findings in 3 cases of unilateral cortical atrophy; no delta activity was observed in these cases, but *alpha rhythm was decreased* on the affected side in 2 cases and *increased* in the third. In 1938, Case and Bucy(3) noted in one case *absence of normal alpha rhythm* over a large localized traumatic cerebral atrophy extending from cortex to ventricle. Rubin(4) found differences in *percent time alpha* activity from the 2 hemispheres in cases of cerebral atrophy but was unable to lateralize the lesions by this method. Davidoff(5) stated that localized abnormalities in the EEG were found in 13 out of 16 cases of brain atrophy demonstrated by pneumoencephalogram. The type of electroencephalographic abnormality was not stated.

Kreezer's(6) claim that high-voltage activity was distinctive for patients with hydrocephalus was denied by Gibbs(7), who stated that the EEG may be normal in cases of hydrocephalus unless obvious neurological signs of gross brain damage are present, under which circumstances abnormalities are found, consisting of high-voltage fast waves, scattered slow waves of 4-7 per second frequency and irregular waves of 1-2 per second frequency.

Trowbridge, Semrad, and Finley(8, 9) found both normal and abnormal waves in cases of cerebral atrophy although there was a preponderance of slow-wave abnormalities in cases with ventricular dilatation. There were no findings peculiar to patients with cerebral atrophy. Similar observations were reported by Sjaardema and Glaser(10).

Electroencephalographic abnormalities have been reported for some cases of multiple sclerosis having pneumoencephalographic findings of brain atrophy(11, 12); the electroencephalographic abnormalities tended to disappear during remissions of the disease.

Since numerous questions still remain unanswered in regard to the EEGs of patients with brain atrophy, we have reviewed our findings in a series of 67 such patients.

MATERIAL AND METHOD

Over a 6-year period, from 1939 to 1945, pneumoencephalography was performed at the Boston Psychopathic Hospital on 214 patients suspected of having brain lesions; of these, 98 patients had essentially normal pneumoencephalograms, 20 had negative pneumoencephalograms except for slight ventricular asymmetry, 8 had demonstrable brain tumors, 6 showed insufficient filling for interpretation, and 82 showed evidence of either cortical atrophy, ventricular dilatation, or both. Of these 82 cases, 67 had EEGs done prior to the pneumoencephalogram, and comprise the basis of the present study.

Of the 67 cases which were studied by both pneumoencephalography and electroencephalography, pneumoencephalograms showed clear-cut bilateral ventricular dilatation in 37 cases; in 8 of these there was also definite evidence of cortical atrophy. In the remaining 30 cases pneumoencephalograms showed cortical atrophy alone with no definite evidence of ventricular dilatation. In all but one of these 30 cases the cortical atrophy was bilateral.

The ages of the 67 cases ranged from 12 to 69 years with an average age of 39 years; approximately half of the cases were between 30 and 50 years of age.

The EEGs were obtained with a Grass 6-channel apparatus by monopolar and bi-

[1] From the Department of Psychiatry of the Harvard Medical School and the Boston Psychopathic Hospital, Dr. Harry C. Solomon, Director.

Able technical assistance in the electroencephalographic recordings was rendered by Miss Marie M. Healey.

polar techniques with added localization by triangulation methods when deemed advisable.

Results

1. *Cases with Ventricular Dilatation.*—Of the 37 cases with ventricular dilatation, there were 12 with a history of convulsive seizures, all of whom had abnormal EEGs. Of the remaining 25 cases with no history of convulsive seizures, only 11 had abnormal EEGs (an incidence of 44% abnormality). In previous series of cases reported in the literature(8, 9) the factor of convulsions has not been given due consideration.

(a) *Types of Abnormal EEGs in Cases With Ventricular Dilatation.*—Electroencephalographic abnormalities were classified according to the Gibbs Scale(13). Of the 12 abnormal EEGs in cases with a history of convulsive seizures, 7 were classified S.2, three S.1, one F.1, and one F.1 and S.1. Three of the 12 cases showed some asymmetrical abnormalities. Two of these 3 showed unequal dilatation of the ventricles and in both the greater electroencephalographic abnormality was on the side of the smaller ventricle.

Of the 11 abnormal EEGs in cases without a history of convulsive seizures, one was classified S.2, five S.1, and five S.1 and F.1. Two of the 11 cases showed asymmetrical electroencephalographic abnormalities but both had symmetrically dilated ventricles.

(b) *Degree of Ventricular Dilatation and Electroencephalographic Abnormality.*—When cases with a history of convulsive seizures were excluded, it was found that there was a greater percentage of abnormal EEGs in those cases with marked ventricular dilatation (63% abnormal EEGs) as compared to those with slight or moderate ventricular dilatation (33% and 50% abnormal EEGs respectively). However, statistical validation is not possible at present because of the small size of the groups involved.

(c) *Asymmetry of Ventricular Dilatation and Electroencephalographic Abnormality.*—Of the 37 cases with ventricular dilatation there were 14 in which one lateral ventricle was considerably more dilated than the other. However, cases with approximately equal dilatation of the two lateral ventricles had about the same percentage of electroencephalographic abnormality as cases with unequal dilatation. This finding applies whether patients with a history of convulsive seizures were included or not.

II. *Cases with Cortical Atrophy.*—There were 30 cases with evidence of definite cortical atrophy but without evidence of ventricular dilatation. Of these 30 cases only 3 had a history of convulsive seizures and all 3 had abnormal EEGs. Of the 27 cases with no history of convulsive seizures, 10 had abnormal EEGs (an incidence of 37% abnormality).

(a) *Types of Abnormal EEGs in Cases with Cortical Atrophy.*—Of the 3 abnormal EEGs in cases with a history of convulsive seizures, one was classified S.1, one F.1 and one petit mal. Of the 10 abnormal EEGs in cases without a history of convulsive seizures, one was classified S.2, three S.1, four F.1 and two S.1 and F.1. In the one case showing lateralizing electroencephalographic abnormalities, the cortical atrophy was symmetrical. It would appear that in cases with cortical atrophy the electroencephalographic abnormalities more often include fast dysrhythmias than in cases of ventricular dilatation.

(b) *Degree of Cortical Atrophy in Relation to Electroencephalographic Abnormality.*—In cases with slight to moderate cortical atrophy the degree of electroencephalographic abnormality was considerably less than in cases with marked cortical atrophy (30% as compared to 57%).

Discussion

The most interesting conclusions emerging from this correlation between EEGs and pneumoencephalograms are as follows:

(1) Many cases with clear-cut cortical atrophy or ventricular dilatation have normal EEGs. Actually only 44% of the cases with ventricular dilatation (without convulsive seizures) and 37% of the cases with cortical atrophy (without convulsive seizures) had abnormal EEGs. In a previous communication Greenblatt, Levin, and Atwell(14) pointed out that the EEG is frequently negative in cases with marked brain damage, particularly those cases in which the damage is either arrested or only slowly progressive.

Greenblatt and Levin(15, 16) also found 50% normal EEGs in cases with proven dementia paralytica.

(2) There is no specific electroencephalographic pattern for cases with cortical atrophy or ventricular dilatation. Earlier writers evidently did not have access to a sufficient series of cases to be able to appreciate the wide array of electroencephalographic changes that may occur.

(3) When convulsive seizures are part of the clinical picture accompanying ventricular dilatation or cortical atrophy, the incidence and degree of electroencephalographic abnormality are high. In our series all cases with a history of convulsive seizures had abnormal EEGs. It is interesting that convulsive seizures were more common in cases with ventricular dilatation than in cases with cortical atrophy, which perhaps points up the significance of the deeper structures in the genesis of epilepsy.

(4) When cases with a history of convulsive seizures are excluded, slow activity is more prominent in cases with ventricular dilatation than in cases with cortical atrophy, and fast activity is more prominent in the latter group than in the former.

(5) There is no direct correlation between focal electroencephalographic abnormalities and unequal ventricular dilation. Of the 5 cases with focal EEGs only 2 had asymmetrical ventricles. In these 2 cases the EEG was more abnormal on the less dilated side. Both of these cases were subject to convulsive seizures.

The pneumoencephalographic diagnosis of cortical atrophy and ventricular dilatation unfortunately depends on criteria that are susceptible to error. For this reason we have dealt only with cases that, in the opinion of the radiologist, were unequivocal. Cortical atrophy and ventricular dilatation may be due to diverse forms of pathology resulting from the operation of various etiological factors such as trauma, encephalitis, carbon monoxide poisoning, cerebral arteriosclerosis, and degenerative diseases. When diverse neuropathological mechanisms are at work, several kinds of disturbances may be produced in the cortical electrophysiology and a variety of wave patterns may therefore be expected in the EEGs.

Summary

(1) In a series of 67 cases with unequivocal pneumoencephalographic evidence of either cortical atrophy or ventricular dilatation, many normal EEGs were found as well as a considerable variety of abnormal electroencephalographic patterns.

(2) Those cases of cortical atrophy or ventricular dilatation having convulsive seizures as part of the clinical picture invariably showed abnormal EEGs. In the majority of such cases the electroencephalographic abnormalities were of a marked degree.

(3) In cases free of convulsive seizures, the electroencephalographic abnormalities were generally of a mild degree, and the incidence of abnormality was similar for cases with ventricular dilatation (44%) and cortical atrophy (37%). However, more slow activity was found in cases with ventricular dilatation than in cases with cortical atrophy, and more fast activity in the latter group than in the former.

(4) Asymmetrical electroencephalographic abnormalities were recorded in only 5 individuals, 2 of whom had unequal ventricular enlargement. In these 2, the greater electroencephalographic abnormality was on the side of the smaller ventricle.

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CLINICAL NOTES

NARCOANALYSIS AND ALLIED PROCEDURES

HARRY L. MACKINNON, M. D., DAYTON, OHIO

During the past 3 years the author has used narcoanalysis and allied procedures as an adjunct to psychotherapy in 130 cases, in both military and civilian practice.

There are some cases in which narcoanalysis is definitely contraindicated. These are, for the most part, patients in whom the giving of an intravenous injection might further increase the anxiety because unconsciously it symbolizes a sexual or death threat. There are also certain types of reactions which cannot be helped by narcoanalysis. In the main, these are the individuals whose defenses are so well established that any treatment will be long and will lead to a difficult transference neurosis. Even if it is explained to the patient that intravenous injections will be given only at the beginning of treatment, the change-over to the interviews alone becomes something on which he can place either his resistance or negative transference. The author learned by his own mistakes that actually at the termination of injections treatment was probably no further advanced than it would have been without the injections and now there was one more obstacle to overcome.

Then, there is a group of more acute cases in which narcoanalysis can add nothing to the therapeutic process. These are individuals who talk freely, have good integrative processes, and cooperate well.

Some acute cases are so severely involved in their defenses that there is little chance for patient and doctor to gain ground. Often these individuals will benefit merely from the relaxation of sedation, and upon awakening the natural curative processes can get a start before the defenses return. What the patient and physician discuss during the interview probably doesn't matter much, and the physician can do more harm than good by "probing." He can be most useful in the "after period" by helping along these "curative drives."

Some acute cases under narcoanalysis immediately begin to face their traumatic episodes or can be encouraged to do so by the therapist. These will abreact powerfully and one can see the restorative effects quite quickly. Such cases were found often in the Army and are sometimes observed in civilian life when a severe or unexpected traumatic situation served as the precipitating factor. In some of the more chronic cases in which the patient would be likely to avoid discussing traumatic experiences for a long time in ordinary interviews, narcoanalysis may shorten treatment.

Then there are patients, mainly those with large hysterical or narcissistic elements, who feel that "something strange or powerful" controls them. They will often respond more quickly if sodium amytal interviews are combined with psychotherapy. In these cases it is important that the patients be placed into a comatose-like state rather dramatically and decisively.

Amelioration following the injection may vary from a few hours to several days; in the latter case it is more than just a reaction to the medicine. It becomes possible, therefore, to make a prognostic estimate by noting how quickly symptoms subside and how long they remain absent.

The author is of the opinion that "truth serum" is a misnomer. A patient can readily lie or withhold information if he desires. At the same time, it is easier for him to talk about "painful" things. Also, it is not likely that deeply repressed material can be brought to the surface. It is more likely that the barbiturate merely relieves the tension enough to allow what is about ready to come to the surface to come out a little more quickly and perhaps more easily.

Intravenous barbiturate administration like psychotherapy may be used as a supportive or an uncovering measure. It may be added to a treatment program at a time when more

support than was expected is needed or when something else besides interviews is needed to further or hasten the process of uncovering. The author does feel that the more experienced the therapist becomes, the less he needs drugs or such procedures as narcoanalysis or narcosynthesis. In other words, narcoanalysis probably does nothing which psychotherapy would not be able to do; it merely may at times hasten treatment results by making the patient more receptive to appropriate psychotherapy.

A word might be said about dangers. Every therapist has probably been concerned about precipitating psychoses by too swiftly taking away defenses. This may happen more quickly if narcoanalysis is used, since one can rapidly take away the secondary phenomena by this means. The author is of the opinion that it is not a good idea to use this type of treatment in cases where defenses are necessary to prevent psychosis and the ego at all times needs support. (However, intravenous barbiturate administration can be used as a supportive measure to relieve tension coming on secondarily in those cases whose egos are ordinarily strong enough to withstand freedom from their defenses.)

It is important, the author thinks, that psychotherapeutic interviews without drug administration be appropriately placed in relation to the intravenous injections. Sometimes these can be alternated, placing the interview just before the injection. In other cases, several intravenous administrations may be followed by several interviews. There are any number of possibilities. Of considerable help has been the evaluation of the part of the material the individual remembers after the injection and the evaluation of the part he forgets. The handling of all these components depends on the therapist's reaction to the particular problems of the individual case.

THE CEPHALIN-CHOLESTEROL FLOCCULATION TEST IN SCHIZOPHRENIA [1]

FRANK H. ZIMMERMAN, M. D., MAE GALLAVAN, M. D., AND MERRILL THOMAS EATON, JR., M. D.

Attention has recently been called to reports of abnormal findings in tests of liver status in schizophrenia(1). Among these reports is one on the cephalin-cholesterol flocculation test of Hanger(2) by de Jong and St. John(3). In summarizing their preliminary report these authors from their findings on diagnosed cases stated that the test can be of help in the differential diagnosis of some catatonic and some other cases of schizophrenia, especially in females. To the studies on schizophrenia we wish to contribute this preliminary report of our findings on the Hanger test on undiagnosed mental cases, and to question the applicability of this test to their differential diagnosis.

The cephalin-cholesterol flocculation test and a number of other related and unrelated tests(4) have constituted an admission routine laboratory examination done since 1945 at the Colorado State Hospital. These admission laboratory procedures are completed before the psychiatric diagnoses are made. Except for the neurosyphilitics, the psychiatric diagnoses are made independent of the laboratory findings. The Hanger test is considered negative when the reading is 0, plus/minus, 1 plus, or 2 plus, and positive when 3 plus or 4 plus.

In 175 consecutive cases diagnosed as schizophrenia none of the 96 males were Hanger positive and 5 of the 79 females (6.3%) were Hanger positive. In a nonschizophrenic group of 210 cases 6 of the 114 males (5.3%) were Hanger positive and 7 of the 96 females (7.3%) were Hanger positive. The nonschizophrenic group consisted of 35 alcoholics, 34 mental defectives, 33 seniles and cerebral arteriosclerotics, 34 manic-depressives, 33 neurosyphilitics, 28 epileptics, and 13 psychoneurotics. All were consecutive cases in these diagnostic categories admitted

[1] From the Department of Psychiatry and the Department of Pathology, Colorado State Hospital, Pueblo, Colorado.

during the same period of time as the schizophrenic group.

The age range of the cases of schizophrenia was from 15 to 70 years with the majority between 30 and 50 and the median at 41 years. In the nonschizophrenic group the age ranged from 13 to 89, the majority being between 34 and 60 and the median at 45. The cases were committed patients and therefore the earliest stages of the disorders are not represented.

Since the schizophrenic cases included in our admission series were not subclassified, it cannot be stated how many, if any of them, were catatonic. As an approach to that phase of the problem 22 institutionalized patients, 12 male and 10 female, were selected as being strictly catatonic and on these the tests were also performed. Since duration of disease might possibly affect the liver state a group of 12, 6 male and 6 female, markedly deteriorated, long institutionalized, schizophrenic patients whose disease had been present for 15 years or longer were also tested. In these selected groups there were no positive tests.

In none of the groups was there a higher number of 2 plus readings.

The results obtained in our series are very different from those obtained by de Jong and St. John, though the studies were of comparable numbers of cases. In their series of cases they found 44.6% positive reactions in female noncatatonic schizophrenics. They found 46.8% positive reactions in female and male catatonic schizophrenics, 6.9% positive reactions in their control group.

The marked difference in results between our series and those of de Jong and St. John would seem to be too great to be satisfactorily explained by differences in the technique of the Hanger test or by differences in the diagnosis of schizophrenia. However, it is to be remarked that very early stages or mild states of the disorder are not found in our admissions and are therefore unrepresented in our series. Therefore, from our work and that of de Jong and St. John we believe that studies with the test and with modifications of the test such as recommended by Neefe and Reinhold (5) and Frisch and Gulligan (6) are indicated in early schizophrenia, where, coincidentally, aids in differential diagnosis and subclassification are most needed.

From our findings we conclude that the Hanger cephalin-flocculation test would not be of help in the differential diagnosis of or the subclassification of schizophrenia in its established stages.

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PRESIDENT'S PAGE

Undoubtedly the National Mental Health Act has been of an enormous value in the further development of psychiatry in the United States even in this one year in which the Act has been in effect. Not all our members may know that its administration is through the Public Health Service. The evaluation of requests for grants-in-aid from the states, from universities and training centers, and from research workers, are all evaluated and recommended or not recommended by a group of outstanding psychiatrists, psychologists, social workers, and nurses. In other words, the Public Health Service acts only as a medium and does so on the recommendation of this advisory group. All of the psychiatrists are members of The American Psychiatric Association.

This year, unfortunately, despite the hope for considerably larger appropriation, the Public Health Service received only about $300,000 more than during the first year of the operation of this act. Both the House and the Senate Appropriations Committees reduced the amount requested although this amount was carefully calculated on the basis of the year's experience as to the great needs for training, research, and community demonstrations in psychiatry, clinical psychology, social work, and nursing. Unfortunately, there was little warning that the Appropriations Committees of Congress would be reducing the amount requested. When your medical director and your president learned of the cut, they took the initiative to contact each member of the Council, all of the affiliate societies and many other individuals, with the hope that our many members could bespeak themselves to their representatives in Congress as to the needs for mental health. The effort, unfortunately, came too late.

The moral of this lesson, however, is that we in psychiatry must be articulate and particularly so in relation to those individuals in our state and national legislative groups. We individually, and as organized groups in various areas of the country, must assume the responsibility of outlining and educating regarding the needs of psychiatry. This cannot be effectively carried out by referring it to the officers of your Association or its public education committee. If our state legislators and our national congressmen and senators are to understand the need for psychiatry, we must be the ones to tell them. Nor are they interested in merely being told that the mental health needs are great; they must be told the "why."

Furthermore, it is not practical for us to wait until an emergency arises to assume this responsibility. This should be a continuing and constant responsibility of every member. I have asked our committee on public education to give us leadership in this job but by no means does this preclude plans or action that might be taken by any and every affiliate society toward informing their own state representatives. I would hope that at the first fall meeting this subject might be on the business agenda of each of the affiliate societies.

Along this same line, it is the hope and intention of your Executive Committee to arrange a meeting with the presidents and secretaries of other psychiatric groups: the Orthopsychiatric, the American Psychopathological, the American Association for Mental Deficiency, the sections on Neurology and Psychiatry in the American and Canadian Medical Associations, and others, with the thought that it would be desirable for all such organizations to present a common front.

The Sixty-Four Dollar Question: Do your senators and congressmen know of the mental health needs in your state and in the nation? All of these remarks are equally pertinent in the Dominion and provinces of Canada.

WILLIAM C. MENNINGER, M. D.

COMMENT

WALTER E. FERNALD SCHOOL CENTENARY—1848-1948

In 1948, the Walter E. Fernald State School, Waverley, Massachusetts, celebrates its one hundredth anniversary.

When the First International Congress on Mental Deficiency held its meeting in Boston May 18-22, 1948, a special session was held on Friday afternoon, May 21, at the School. The Massachusetts School for the Feeble-minded which now carries the name of Dr. Walter E. Fernald, its superintendent for 37 years, is the oldest institution of this type in America, and its history reflects the changes in attitudes throughout the 100 years of its existence.

Dr. Samuel Gridley Howe (born in Boston, 1801) spent several years in Europe and became interested in the care of the blind. Later, when a member of the Boston School Commission, he extended his interest into the field of the mentally defectives and requested an investigation into "the number and conditions of idiots in Massachusetts." The first comprehensive study was made, "By addressing a circular letter which contained a list of questions to the town clerk of each city and town in Massachusetts. By inspecting personally as many idiots as possible in order to ascertain their condition and capacity, so as to be able to form a more just estimate of the whole. By obtaining accurate and minute information concerning such schools which have been established in France, Prussia and Switzerland."

This survey was started in March 1847 and a report presented to Governor Briggs and the Legislature of Massachusetts Feb. 6, 1848, by Dr. Howe, chairman of the State Commission. It was stated that "five hundred and seventy-four human beings condemned to hopeless idiocy and left to their own brutishness," were found.

After Massachusetts had taken the first step, other states followed.

The care of the feeble-minded was based on observations originating in France and was first concentrated on training and education. Under the influence of the growing natural sciences the study of idiots attracted increasing medical interest. Bourneville in France opened his series of investigations on the pathology of various types of mental defects as early as 1863 and continued this research for 40 years. Many other scientists followed, such as Mierzejewski, Ireland, Shuttleworth, and Kundrat. As early as 1890, A. W. Wilmarth was able to publish a "report on the examination of one hundred brains of feeble-minded children."

Until 1875, Dr. Howe acted as head of the Massachusetts School for the Feeble-minded, but no permanent superintendent was appointed. After Dr. Howe's retirement, Dr. Jarvis had charge of the School. He died in October 1884, at the age of 82 years. He was the second general superintendent, who gave 30 years of his time and labor.

In 1887 Dr. Walter E. Fernald was appointed the first resident superintendent of the School, which was finally moved to its present site in Waltham in 1890, when the first new building was completed. Dr. Fernald was superintendent of the School until his death in 1924. "Under his wise guidance and humane administration the School became a model for the whole world," so reads the inscription on a tablet presented by devoted employees.

Dr. Ransom A. Greene succeeded Dr. Fernald as the second resident superintendent July 1, 1925, and after 20 years of service retired August 1, 1945. On October 5, 1946, Dr. Malcolm J. Farrell, formerly assistant to the chief of the neuropsychiatric division, Surgeon General's Office, succeeded Dr. Greene as superintendent of the School.

While in the first 70 years of its existence the Walter E. Fernald School was the spiritual leader in education and care of mentally defectives, a new era of scientific importance began, when Dr. Fernald in association with Dr. E. E. Southard, Bullard Professor of Neuropathology, and Annie E.

Taft, Custodian of the Neuropathological Collection, Harvard Medical School, began a series of research studies later published as the "Waverley Researches in the Pathology of the Feeble-minded." The first research series, Cases I to X, was published in May, 1918. Under the participation of Drs. Southard, Fernald, A. E. Taft, Oscar J. Raeder, Myrtelle M. Canavan, and Louise Eisenhardt, 50 cases were collected and published over a period of 22 years. This scientific research in the causes of mental deficiency received new impetus when in 1939 the Fernald School opened its own research department, whose first director was Dr. Paul I. Yakovlev. Dr. Yakovlev left the School in 1947 to become assistant professor of neurology at Yale and director of psychiatric education at Connecticut State Hospital, Middletown, Conn. Dr. Clemens E. Benda, who was the first director of the Wallace Research Laboratory in Wrentham and later director of the child unit at the Metropolitan State Hospital in Waltham succeeded Dr. Yakovlev in October 1947. The research unit has published a large number of investigations. An exhibition, "The Anatomy of Mental Defect," was shown in May and will be opened again in the fall.

In a new era of scientific research the understanding of mental deficiency has greatly increased. Mental deficiency is a symptom and not a uniform condition. As a medical problem it has become a part of pediatric neuropsychiatry. The lines of demarcation between child psychosis and mental defect are less definite than earlier publications seemed to indicate. While general psychiatry is finally awakening from the lull of pessimistic and defeatist institutional care, child psychiatry is still slow in adopting the field of mental deficiency as an integral part of its own discipline. When it will be generally recognized that the mentally defectives are not only an educational and psychological problem, but patients who need attention from psychiatrists, pediatricians, and neurosurgeons, the care of the defectives will enter a new era in which progress may be witnessed similar to that in other fields.

"The care of the mentally feeble-minded children of a state reflects accurately the religious conceptions, the medical science, the educational and judicial standards of a state." This statement was made 100 years ago. If it is true, contemporary psychiatrists will have to ask themselves whether they live up to the expectations of the last century, or whether the field of mental defect is slipping behind the generally accepted standards of modern psychiatric hospital treatment.

MALCOLM J. FARRELL, M. D.
CLEMENS E. BENDA, M. D.

RESEARCH IN PSYCHOTHERAPY

A therapist's first obligation is to his patient. While treatment is still in progress it is not easy for him to free himself from the emotional pressure of his therapeutic responsibilities; but even after the therapeutic task has been completed and therapeutic obligations have been discharged, he often continues to focus his interest upon evaluating his efforts as a therapist and may find it difficult to achieve the detachment of a scientific observer toward what has occurred in the course of the treatment.

It is for this reason that research in psychotherapy is so often confused with evaluation of therapeutic results. In reviewing his efforts and their results, a therapist usually has a strong urge to evaluate his performance as a whole as "good" or "bad" from the point of view of the patient's interest and the goals of therapy. In this he is motivated by a continuing sense of therapeutic responsibility, by pride, or by guilt. But evaluation of a therapy as "good" or "bad" is quite irrelevant for a scientific inquiry, and the underlying motives of pride or guilt may seriously distract the therapist from his scientific purpose. His task as a scientific investigator is not to evaluate but to try to understand quite objectively what has happened, as a chain of cause and effect.

There is a good reason why it is impossible to learn very much from our usual statistical methods of evaluating therapeutic procedures. In evaluating therapeutic results we

usually compare the patient's behavior before and after treatment and attempt to judge the success of the treatment as a whole. But a psychotherapeutic treatment may last many months and in the course of such a long time the therapist usually says or does or fails to do many things that are of significance to the patient. Such a treatment is not one but a long series of many clinical experiments. If the patient's reactions to the treatment are to be understood as a chain of cause and effect, then obviously the results of each experiment must be studied separately, not jumbled all together in an attempt to evaluate the therapy as a whole.

As an example of a single therapeutic experiment let us consider a hypothetical but typical case. We observe that a patient regularly reacts to certain topics by boasting or showing off. We infer that these topics are associated with something that is very humiliating to him. By alluding to these topics in various ways we attempt to establish the correctness of our initial observation. If further observation confirms this initial impression, we plan a procedure to desensitize him so that it will become easier for him to discuss the disturbing topics and ultimately even to tell us the experience that was so humiliating to him.

In all essential respects this procedure is equivalent to an experiment in a laboratory: first, we observe the patient's behavior and make a hypothesis concerning its motivations; then, if observation of further behavior confirms the hypothesis, we plan a simple procedure to modify the behavior in a way that we predict; next, we carry out the plan and observe whether the results are those predicted. This simple therapeutic experiment is designed to test the validity both of our initial diagnosis of the patient's emotional situation and of our predicted results based on a deliberate plan to change the initial behavior pattern.

The method just described is employed with variation as part of the teaching program in a number of training centers in this country. In order to utilize it for scientific investigation of the therapeutic process, we need only repeat the experiment a number of times in similar situations. As an example the situation cited is more or less typical and will undoubtedly occur at some time in the treatment of many patients.

To set up an experiment in therapy, it is suggested that a group of therapists meet at specified intervals to discuss their handling of a series of more or less similar cases. At each meeting the current emotional situation of one or more of the patients is discussed. Each therapist makes a diagnostic interpretation of the situation, proposes a therapeutic procedure, and predicts results. The therapist responsible for the case carries out the procedure that seems best to him. After an interval, he reports to the group the patient's reactions to the therapy; these are studied and checked against the predictions. Ultimately, we should be able to assemble and compare these data, gathered from the treatment of similar conditions of frequent occurrence in different patients, and to derive from them both the diagnostic rules for recognizing typical conditions and general principles to guide us in handling them.

THOMAS M. FRENCH, M. D.

INTERNATIONAL COUNCIL FOR THE MENTAL HEALTH OF CHILDREN

A notable development in the field of health on an international basis is the recent establishment of the Council for the Mental Health of Children. Very appropriately, the first president of the International Council is the pioneer in child psychiatry, Dr. Leo Kanner, of the Johns Hopkins University School of Medicine. The vice-president is Dr. M. Tramer, editor of the *Intern. Zeitschrift fuer Kinderpsychiatrie,* Bern, Switzerland. The acting secretary is Dr. Ernest Harms, editor of *The Nervous Child,* New York City. This latter publication will serve as the avenue of communication and interchange for the members of the Council.

Already 12 countries are represented in this new organization. These countries with their member representation are as follows: Argentina (8), Brazil (6), Canada (1), Chile (26), Colombia (1), Finland-Suomi

(1), Holland (1), Mexico (8), South Africa (3), Sweden (3), Switzerland (2), and the United States of America (32).

In a letter to the International Council President Kanner says:

The response to the call for the organization of an International Council for the Mental Health of Children has been most gratifying. The number and the high calibre of the charter members testifies to the timeliness of the appeal and guarantees seriousness of purpose and adequacy of procedures.

Now that the International Council for the Mental Health of Children has become a reality, the days of preparation can be considered as concluded and this message may serve as the roll call for planned action.

It is hoped that in the near future a special issue of *The Nervous Child* will be devoted to formulations of workable issues by members of the Council.

May I add that membership in the Council is invited from the ranks of all those who are actively interested in the wholesome development and maintenance of mental health of children everywhere? There shall be no room in the Council for geographic limitations, interprofessional controversies, or doctrinaire strife.

The secretarial office of the International Council is at 30 W. 58th St., New York City.

NEWS AND NOTES

NATIONAL COMMITTEE FOR MENTAL HYGIENE, 39TH ANNUAL MEETING.—The 1948 annual meeting of the National Committee for Mental Hygiene will be held November 3 and 4, 1948, at the Hotel Pennsylvania, New York City. There will be 4 scientific sessions, a business luncheon on the first day, and the annual luncheon on the second day, at which the presentation of the Lasker Award will be made and the 10-year national program for mental health discussed.

The first scientific session will be devoted to international matters emerging from the International Congress on Mental Health recently held in London, the program of UNESCO and the World Health Organization, and the newly organized World Federation for Mental Health. The second session will be a current perspective and evaluation of the Federal mental hygiene program. The third session will focus on the development and responsibility of the citizen for improvement of the state psychiatric services, and the fourth session will clarify the foundations for positive mental health and the activities supportive of this goal.

The Lasker Award for 1948 will be for a recent significant contribution to the education of the physician in the psychological aspects of the practice of medicine (by "physician" is specified the nonpsychiatric practitioner).

VOLUNTARY ADMISSIONS AUTHORIZED AT SAINT ELIZABETHS HOSPITAL.—The 80th Congress passed a law (Public Law 737) authorizing the voluntary admission of patients legally domiciled in the District of Columbia to Saint Elizabeths Hospital. The provisions of the law, which becomes effective in August, 1948, are similar to those prevailing elsewhere: the patient makes written application; the superintendent determines his competency thereto; if under age 21, parent or other legal representative completes the written application; patient may not be detained more than 3 days after he (or legal representative in case of a minor) gives written notice requesting release; during these 3 days regular commitment proceedings may be instituted if necessary. It is hoped that the example of this great Government institution may have effect in the few remaining jurisdictions in which the voluntary admission of patients is still not permitted. It is our information, which we will gladly correct if in error, that there are only 6 states without a voluntary admission provision, viz., Alabama, Florida, Georgia, Mississippi, Missouri, and North Dakota.

THE INTERNATIONAL CONGRESS ON MENTAL HEALTH.—The United States was represented at the International Congress in London, August 11-21, by the following delegation appointed by the Secretary of State:

Dr. Winfred Overholser, superintendent, Saint Elizabeths Hospital, Washington, D. C., chairman.

Ruth Addams, specialist, Community Nursing, Veterans Administration.

Col. John M. Caldwell, Jr., M.C., USA, chief, Neuropsychiatry Consultants Division, U. S. Army.

Dr. Martha Eliot, associate chief, Children's Bureau, Social Security Administration.

Dr. Robert Felix, medical director, Mental Hygiene Division, U. S. Public Health Service.

Capt. Frederick L. McDaniels, M.C., USN, chief, Professional Division, Bureau of Medicine and Surgery, U. S. Navy.

Mary E. Switzer, assistant to the administrator, Federal Security Agency.

Dr. Harvey J. Tompkins, chief, Neuropsychiatry Division, Veterans Administration.

POSTDOCTORAL RESEARCH AND TRAINING IN PSYCHOTHERAPY.—The counseling center and the psychology department of the University of Chicago announce a postdoctoral research and training program in client-centered therapy for a limited number of qualified persons from the fields of clinical psy-

chology, student counseling, psychiatry, or psychosomatic medicine.

The program, which will run continuously after October 1, 1948, will be under the direction of Professor Carl R. Rogers of the department of psychology. The work will consist in seminars and opportunity to participate in other courses and training and research activities.

It is desirable that candidates should spend 12 months in the program; but under special circumstances they may be accepted for 9 months or 6 months.

The University has waived all tuition fees for those enrolled in the program who have a Ph.D. based in part upon a psychological dissertation or who have an M.D. and are interested in psychiatry or psychosomatic medicine. For living expenses various forms of financial assistance are potentially available, as well as a small number of paid staff positions at the counseling center.

Applications will be accepted from persons under 40 who have a Ph.D. or M.D. degree, and who have special qualifications in clinical psychology, student counseling, psychiatry, or psychosomatic medicine. For further information write to Dr. Carl R. Rogers, Executive Secretary, The Counseling Center, University of Chicago, Chicago 37, Illinois.

EXCERPTA MEDICA—NEUROLOGY AND PSYCHIATRY.—*Excerpta Medica* is a new Netherlands review supported by a group of Dutch publishers and established as a Foundation administered by a Board of Trustees consisting of professors of the University of Amsterdam and other Netherlands universities. The Chief Editorial Board includes three members: M. W. Woerdeman, M.D., professor of anatomy and embryology; A. P. H. A. de Kleyn, M.D., professor of otorhinolaryngology; and W. P. C. Zeeman, M.D., professor of ophthalmology, all in the University of Amsterdam.

Excerpta Medica comprises 15 sections representing all medical fields and which undertake to publish monthly in English abstracts of all important articles in the fields of clinical and experimental medicine from every available medical journal in the world.

Section 8 of *Excerpta Medica* is devoted to reviews of the literature on neurology and psychiatry and is under the direction of a special board of 37 editors scattered over the world, of whom 8 are from the United States and one is from Canada. The first number of this section, recently received, is dated January, 1948, and contains 256 abstracts and references. The price per volume of the Section on Neurology and Psychiatry, comprising about 900 pages, is $22.50. The publication office of *Excerpta Medica* is 111, Kalverstraat, Amsterdam C., The Netherlands.

SECOND INTERNATIONAL SYMPOSIUM ON FEELINGS AND EMOTIONS.—The Loyal Order of Moose, with the cooperation of the University of Chicago, is sponsoring this symposium October 28-30, 1948. The Mooseheart Symposium, under the general chairmanship of Dr. Martin L. Reymert, director of the Mooseheart Laboratory for Child Research, marks the 20th anniversary of the publication, "The Wittenberg Symposium on Feelings and Emotions." Dr. Anton J. Carlson, professor emeritus of physiology at the University of Chicago, is honorary chairman.

The list of contributors will include 40-45 scientists in various disciplines from different parts of the world. The sessions on October 28 will be held at Mooseheart, Illinois; those on October 29 and 30, at the University of Chicago. In planning the program, Dr. Reymert will be assisted by Dr. Carlson and Dr. James G. Miller, of the University of Chicago, Dr. Herbert Langfield of Princeton University, and others. All sessions of the conference will be open without tickets to all interested.

There will be open house for all who wish to visit Mooseheart, the City of Childhood, on Wednesday, October 27, and Sunday, October 31.

For information concerning hotel accommodations and other matters write to Dr. Reymert. A housing committee will be established in Chicago. Participants will be given gratis transportation between Chicago and Mooseheart through the courtesy of the Moose Fraternity.

DR. BRUSSEL WINS LITERARY PRIZES.—Dr. James A. Brussel, assistant director of the Willard State Hospital, has been awarded

first and second prizes in the 1948 national contest of the American Physicians' Literary Guild, which was held in conjunction with the A.M.A. convention in June. The awards were for a satirical opera, "Dr. Faust of Flatbush," and for a short story, "Café au Lait." Dr. Brussel has captured first and second prizes every year since the contest started 3 years ago.

DR. SANDS DIRECTOR OF RESEARCH AT WORCESTER.—On July 1, 1948, Dr. Sidney L. Sands assumed the position of director of research at the Worcester State Hospital. He succeeds Dr. William Malamud, now professor of psychiatry at Boston University.

Dr. Sands, a graduate in medicine from the University of Iowa, joined the staff of the Worcester State Hospital in 1940. In 1941 he entered the military service and was demobilized with the rank of lieutenant colonel in February, 1946. He served as division neuropsychiatrist for the 66th Infantry Division, saw combat service in the E.T.O., and was awarded the Bronze Star. He returned to Worcester State Hospital shortly after leaving the Army, assuming the position of senior physician in research.

Dr. Sands is a member of The American Psychiatric Association, the New England Society of Psychiatry, and the Massachusetts Society for Research in Psychiatry. He is a Cooperating Fellow of the Worcester Foundation for Experimental Biology.

THERAPEUTIC EFFECT OF SODIUM AMYTAL.—As result of experimental studies, Delay and Mallet (L'Encephale, 37, No. 5, 1948) conclude: "The principle action of the drug is to calm the emotional states and consequently to diminish in some degree repressions and inhibitions. Its action, therefore, is a depressive one and purely cortical or predominantly so, and beginning with the frontal lobe. It is only when the phase of sleep is reached that the central regions of the brain are considerably depressed."

PSYCHOSOMATIC HUMOR.—We had not credited *Psychosomatic Medicine* with a sense of humor, but we were wrong. The May-June 1948 issue of that journal reprints as an editorial a poem from *The New Yorker* poking fun at psychosomatic medicine. The poem is entitled, "Don't Shake the Bottle, Shake Your Mother-in-Law."

BOOK REVIEWS

NUREMBERG DIARY. By *G. M. Gilbert.* (New York: Farrar, Straus and Company, 1947.)

Scientific reporting is extremely difficult and this volume, a day-by-day running account of the expressed opinions of the major Nazi war criminals, is an attempt to report their psychological structures in diary form. It achieves its fundamental aim but suffers in that the major characters may well be almost unknown to many of its readers. This is not an intended criticism of the volume but rather a criticism of the lack of interest of the average American in the individualities who precipitated the world into the recent holocaust of war.

To anyone knowing the criminals and their history, the book is most interesting and from it considerable information concerning the personality makeup of these particular Nazis can be gained. The author's opportunities for observations were unlimited, and the diary is of value historically as well as psychologically.

Fortunately, the volume is primarily a summary of the various statements of the prisoners, both to each other and to the observer, put down in most cases nearly verbatim. The author states, "I refrained from embroidering the data with too much psychological speculation, leaving that to later collaborative studies which would be more comprehensive and objective than my own immediate reactions could possibly be." Such an attitude is most commendable and, as a result, this book represents a source of information concerning these individuals which should prove of considerable research value. The author occasionally introjects his own interpretive concepts and at times is forced through lack of space to make some selection of his material. Naturally, this colors, to some degree, the over-all picture of the individuals concerned, but for the most part the portrayal of each character is adequate and essentially accurate.

The book serves a useful purpose since it demonstrates the interplay of the various personalities concerned in a special situation. It cannot be overemphasized, of course, that all observations of these individuals after their incarceration at Nuremberg must be considered as studies limited by the fact that each captive Nazi was held under the shadow of death as a war criminal. Obviously, this environmental situation produced a varied series of reaction patterns, in some instances undoubtedly different from the precaptive personality expression. If this consideration is borne in mind, the personalities of the various Nazi leaders become more understandable and the various jealousies, attitudes, and reaction patterns become more realistic. This, then, is a specialized report dealing with a special phase in the lives of the men considered as the major leaders of the Nazi party. It represents a set of reaction patterns of the Nazi virus in captivity. By itself the volume is interesting reading. In connection with documents of the trial, together with life histories of the individuals concerned, it completes a gap which should prove of value in future sociopsychological consideration of these most infamous men.

DOUGLAS M. KELLEY, M. D.,
Bowman-Gray School of Medicine,
Winston-Salem, N. C.

PSYCHODRAMA. First Volume. By *J. L. Moreno, M. D.* (New York: Beacon House, 1946.)

The author traces the development of psychodrama from the day of its conception, not only to the present, but to the future, in which he envisions "psychodramatic sessions to be broadcast from a television station to the world." It would seem somewhat premature, to say the least, to plan for such universal use when many aspects of this therapeutic endeavor remain to be investigated and clarified.

This imposing volume is divided into 8 sections, each of which constituted a discussion of such phases of the topic as the therapeutic theatre, creative revolution, principles of spontaneity, and sociodrama. There is an air of profundity which when investigated reveals the book's greatest handicap, that of a veritable Webster of new terms, many without lucid definition. This makes criticism of the actual content frequently impossible since this writer was ofttimes most puzzled at the author's production. Dramaturgy, creaturgy, and matrix of identity are pertinent examples.

Dr. Moreno has spent much effort in developing a hypothesis regarding the development of the infant from birth to his "first safe anchorage in the new world." When taken out of context the following quotation is only slightly more surprising: "Our conclusions, therefore, are that any prolongation of the human pregnancy would be a calamity for the infant, that its length seems rather well planned than otherwise, and that the infant is born at a strategic moment for the development of his spontaneous potentialities" (p. 64). It would appear, then, that the author has devoted much effort in speculation in an area not too productive of increased understanding of the phenomenon of psychodrama.

The need for further investigation into the principles of psychodrama is great, for as a therapeutic procedure it holds promise. The need is great also for a clear description of the principles already established, without which further investigation certainly is hampered. This volume, therefore, is recommended only to those who desire a historical review and bibliography on the subject of psychodrama.

LEON YOCHELSON, M. D.,
St. Elizabeths Hospital,
Washington 20, D. C.

THE PSYCHOLOGY OF BEHAVIOR DISORDERS: A BIOSOCIAL INTERPRETATION. By *Norman Cameron, M. D., Ph. D.* (New York: Houghton Mifflin Company, 1948.)

Crowded between the covers of this book are a very great many facts about the human personality and the deviation of behavior of which it is capable. In many places the book is like good poetry in that it verbalizes clearly and satisfyingly ideas that have been thought in the past but which have not been brought to finite formulation and expression. There are also insights which are original and serve to give meaning to clinical experience which it had not had before.

Though the book is profoundly dynamic in philosophy, it does not make the too common error of assuming that using psychoanalytic terminology is synonomous with psychodynamics. Similarly, the discussion of psychotherapy, though it is appropriately short in a volume primarily devoted to behavior disorder, is expressed in words that force a rethinking of concepts. Because of the originality of presentation, this is not a book one can skim through easily. The writing is smooth and never stands in the way of understanding. The material to be understood, however, is so stimulating that each page draws out of the reader contributory material from his own experience to be thought through before going on to the next paragraph. The book makes the reader a collaborator in the work of understanding behavior disorder; it is not a free gift requiring no effort of the reader.

The discussion of personality development deals with the significance of the factual happenings which take place as the individual grows in our culture. For the most part, Cameron eschews the use of the common generalizations about development. There is little to be found about the Œdipus situation, for example, though the facts which led to the evolution of that concept are discussed. Similarly, the ego, the id, and the superego and even the animistic concept of the unconscious rarely appear, though the factual circumstances usually gathered together under these headings are more courageously faced by Cameron than by many who use the Freudian shibboleths without having faced the facts.

The classification of behavior disorders is arresting and different from the usual. No clear-cut distinction is made between psychoses and neuroses, each type of reaction having the equal hierarchal value as a reaction of the personality. Cameron conceives of behavior pathology as being the exaggeration and perversion of some part of normal human behavior. With the description of each reaction type there is a discussion of the types of life situations out of which such reactions may rise. There are cases presented which illustrate the conclusions drawn. As is dictated by the state of development of psychiatric knowledge and research, there are no controlled statistical data to support the conclusions and the reader is confronted with the question, "Why don't all persons with this type of background show this reaction?" Cameron for the most part rejects the answer of hereditary or constitutional factors. He prefers to leave the question open for further research, feeling that to accept constitutionalism, the easy way out of the dilemma, will serve only to block further inquiry. All psychiatric syndromes secondary to cerebral incompetence are treated as a unit on the basis that, fundamentally, they are disorders that would have appeared in the individual had any other sufficient precipitating insult than central nervous system damage forced the personality from its usual reaction patterns. The concept is similar to that so popular during the war, when it was said that the threshold for the appearance of pathological behavior was lowered by fatigue, exposure, and indiscriminate sensory stimulation until a pattern of pathological behavior appeared, the particular reaction being dependent upon determinants in the past of the individual. The concept is a healthy one for keeping interest in organic case material alive, rather than relegating it to an incurable status not worthy of understanding in terms of psychodynamics.

While avoiding the dualistic thinking implied by such terms as psychosomatic and psychobiological, Cameron nevertheless introduces a new dualism on another level of human functioning with the term biosocial. These originally hyphenated terms have a place in the progress of a science, and though one is critical of the dualisms they conceptualize even as they strive to eliminate them, they have served to center attention on problems of the greatest importance in psychiatry. At the moment, psychiatry undoubtedly needs its attention directed to the fact that man's reactions are not individual but social in a very large proportion of situations. Eventually, the word biosocial along with the other dualisms may be outgrown, their implications being included in a broadened concept of the biology of the human being.

The book is well set up and the print is easy to read. The publicity concerning the book makes much of the fact that the author is more than adequately trained in both psychology and psychiatry. The two fields are so well integrated that the reader is aware only of a broad and eclectic outlook on the part of the author. The book is highly recommended to those who like to think hard as they read and are willing to tread original paths in the field of psychopathology.

PAUL V. LEMKAU, M. D.,
Baltimore, Md.

THE DOCTOR OF MAGIC. By *Frank Deane.* (Prairie City, Illinois: The Press of James A. Decker, 1947.)

The blurb on the cover describes this book as "the strange and beautiful story of a practising magician in a modern and disbelieving world—a narrative in verse which the reader will find engrossing, exciting—and disquieting." Actually, this book is more than that. Sometimes an interesting book can be built, or written rather, around a single theme, a simple idea which, when expanded with all its associations and elaborations becomes a small opus, an arbeit, a fairly complete creation and

representation of a thought; such is the case with this, a story that is worth reading for itself. It is clearly a phantasy based on fact, no doubt, that tries to bridge the chasm between the realm of reality and the kingdom of make-believe with its more solid foundations on the latter side. Frank Deane has set himself the task of constructing this bridge and has done it well—not too stylistically as far as his writing goes, but definitely with punch and clarity insofar as this difficult subject can be clarified. One wonders how the idea came to him, after he has rendered it so effectively as he does in this slim volume. The form is free verse or polyphonic prose, "cadenced" as Amy Lowell used to call it, simple but strong narrative with singularly good description and suggestive power. The plot does not lag although suspense is present and is sustained. This yarn might even make a good thriller or James Mason movie for devotees of the eerie. Congratulations to Frank Deane, whoever and wherever he may be, for an unusual if not unique contribution to the literature of psychiatry. This book does much to bring magic back into medicine.

MERRILL MOORE, M. D.,
Boston, Mass.

THE THEATRE OF SPONTANEITY. By *J. L. Moreno, M. D.* (New York: Beacon House, 1947.)

The author of this volume is one of a small group who, for years, has been interested in relations between psychiatry and the social sciences. Dr. Moreno is known particularly for his inquiries into the sociology of psychiatry as well as for his psychiatric investigations of sociologic problems.

This book is a rewritten version of the original *Das Stegreiftheatre,* first published in 1923. As such it should find a receptive audience among those interested in psychodrama and its derivatives: sociometry and sociatry. In this regard, it is to be regretted that Moreno saw fit to cast the translation of this early work in the form and phraseology of later studies, for the anachronism which results decreases the book's historic value for workers in the field.

"The Theatre of Spontaneity," as it is now presented, is a synopsis of the basic principles of psychodrama. These are contained in 4 chapter-parts. The first part called "The Theatre of Conflict" is essentially a dramatis personae. The second part, presented in 3 sections and titled "The Theatre of Spontaneity," elaborates the major theme. It contains a sketch of what is called "the meta theatre"—its underlying aesthetic and philosophic theory, the dramaturgic principles which govern its function, annotations much like program notes, a discussion of the staging and production techniques as well as an exposition of the applications and implications of psychodrama. The third part is called "The Therapeutic Theatre"; it is a brief outline of the psychodynamics of the "spontaneity principle." The fourth part titled "The Theatre of the Creator" is a religious variant of the foregoing parts. The book concludes with 14 pages of what amount to footnotes. These range from a historical discussion of the theatrical antecedents and relations of the *Stegreiftheatre* to abstracts of psychodrama's critical newspaper notices and a glossary of its terms.

In a general way, "The Theatre of Spontaneity" describes the conceptual origin and development of psychodrama. It appears to be theoretically rooted in an offshoot of neo-Kantian philosophy which, while it is emphatically subjectivistic and highly personal, nevertheless attempts to be objective and interpersonal in its methodology and action. Perhaps the difficulty inherent in an acceptance of this synthesis is the reason why Moreno's critics find it difficult to follow and interpret the permutations and implications of his dialectic. Then, too, like most theorists concerned with philosophic and psychologic matters, Moreno lacked an adequate means of familiar communication. Of necessity he coined words and thereby, unfortunately, added a semantic difficulty to the existing conceptual one. This all too familiar failing among psychologists, psychiatrists, and other social scientists defeats communication. Moreno's mite is no exception: such words as tele, metapraxie, creaturgy, and theometry make hard going the more difficult.

Judged in its own light, however, the material presented in this book can be seen as the historical nucleus for the subsequent influence which psychodrama has had upon some schools of psychology, sociology, and aesthetics. Subjectivity, the essence of which is spontaneity, "the matrix of creativity," as Moreno calls it, is the tour de force of psychodrama. As such it is akin to the free association of psychoanalysis; by the same token it is antithetic to any social or individual procedure which relies upon fixed or stereotyped devices to elicit participation or response. However, psychodrama is explicitly a social or group phenomenon concerned with the interpersonal actions of roles more or less spontaneously assumed and portrayed.

The overwhelming need for an effective social therapy based on sound psychosocial therapy behooves social scientists to pool their knowledge and resources and to scrap their sectional differences in behalf of a system (or systems) which articulates the best functions of many approaches. Whatever might be said of Moreno, it is obvious that he is aware of this. This book is his *apologia pro labor sua.*

HOWARD P. ROME, M. D.,
Rochester, Minn.

FATIGUE AND IMPAIRMENT IN MAN. By *S. Howard Bartley, Ph. D.* (New York: McGraw-Hill Book Co., 1947.)

This is an important book and deals with a subject of wide interest. It gives a comprehensive survey of the subjects of fatigue and impairment from both psychological and physiological aspects. The authors conceive fatigue as a personalistic phenomenon, not confined to one tissue or organ but involving the organism as a whole; nor can it be explained simply upon an energy basis. By impairment is meant the deterioration in the condition of a tissue which can be studied only by physiological and biochemical means. The English is

clear and direct and the subject presented in a logical and interesting fashion which even one not familar with the field can read with profit and enjoyment. The outline given in the second chapter of the various and contradictory conceptions of fatigue emphasizes the confusion which exists as to the fundamental factors concerned. In the chapters which follow much light is thrown upon this complex problem, and the relations of muscular exertion, anoxia, environmental temperature, hours and conditions of sleep, and other physiological considerations are fully set forth and the importance of visual maladjustment, conflict and frustration, disinterest and boredom in the development of fatigue is discussed. The work is an outcome of researches carried out by the senior author upon pupillary reflexes, when the conception of conflict in the causation of fatigue was originally formulated.

N. B. Taylor, Ph. D.
University of Toronto.

Psicanálise e Psiquiatria. By *J. Alves Garcia.* (Rio de Janeiro: Privately published, 1947.)

After a thorough reading of the Spanish translation of Freud's works, Dr. Garcia undertakes a thorough repudiation, and in 123 pages attempts to demolish general freudian principles and specific features alike. Freud, he agrees with Maylan, must have had an Œdipus complex that more properly might have been called a Freud-complex. Lacking all scientific value, Freud's works have nevertheless exercised an undue influence on some people, due to the brilliant literary style, which won the Goethe prize, but which essentially was pure propaganda. Freud himself was megalomanic. His views are antimoral in an ethical sense, primitive, barbarous, and crassly materialistic as philosophy, and wrong in regard to neurosis and sexuality. Dr. Garcia presents no original confutations but depends on Weininger, Hoche, Charcot, Janet, and G. Marañon for arguments. In general the whole system is a myth, as Freud's use of the Œdipus legend shows. The thesis of totem and tabu is absurd, for the Brazilian Indian tribes have incest restrictions, though they never heard of Œdipus; the author believes them to be due to sound eugenical considerations. In conclusion he considers the rules of analytic training centers pure bosh, and the whole training idea comparable to the farce portrayed by Moliére in *Le Malade imaginaire.* The popularity of analysis in the United States he attributes to the inferior education in the humanities as contrasted to education in material subjects, citing Abraham Flexner as authority for this statement. Indeed, the author takes a dim view of the whole science and its professors and supporters.

Bertram D. Lewin, M. D.,
New York, N. Y.

Personality in Handwriting: A Handbook of American Graphology. By *Alfred O. Mendel.* (New York: Stephen Daye Press, 1947.)

This book has several parts; a foreword by Rudolph Arnheim, a general introduction, a chapter on primary principals, three main divisions entitled "At First Sight," "At Second Sight," and "At Third Sight," an appendix dealing with the psychopathology of handwriting with a chapter contributed by Alfred Kanfer on the "Physiology and Pathology of Handwriting" and finally an index.

In the section "At First Sight" there are chapters devoted to style evaluation, the margins, spaces, directions of lines, the slant, pressure, and writing zones. These are fairly orthodox. On page 50 the author describes his method of scoring the style value, which is a long step in the right direction.

"At Second Sight" includes chapters on symmetry, legibility, size, connections and spacing of letters, pace of writing, and concealing and counterstrokes. Without subscribing to many of the author's conclusions this section may also be described as generally accepted material.

"At Third Sight" the author emphasizes the importance of the down stroke which he describes as the "stabile axis" and the significance of lateral strokes (mobile axis) as well as other special features such as circular, initial, and end strokes and simplification. In this section the writer frankly attempts to adapt Freudian psychology to handwriting interpretation. Although this should not be difficult, with so embryonic a study as graphology and so all-embracing a system as dynamic psychology, the examples given are not convincing.

The references and handwriting examples that occur on almost every page are frequently somewhat vague. The informed will find many points of interest in the author's views and emphasis but the novice will be misled by passages that are pure conjecture, controversial, oversights or frank errors. This criticism is made advisedly since handwriting interpretation is not yet past the stage of criticism of women's hats. Anyone who maintains that womens' hats are of no significance is not a realist. One might write an interesting book on the subject of hats but much of it should not be too dogmatic. Unfortunately the book being reviewed does not always divide what we know from what we may believe or suspect at this stage of graphological development.

Most workers would approve wholeheartedly of Chapter 19 dealing with simplification, and much of Chapter 18 on circular strokes is accepted and all of it stimulating. However the chapter on psychopathology and references to paranoid or epileptic characteristics of writing would better be omitted altogether. This might well be said of the chapter on physiology as well, if only for the reason that the author attempts to divide handwriting into a dualistic act, part physical and part psychological. If he can so separate behaviour there is no hope of a science of graphology.

Despite these criticisms there is much of value in the book which deals with a difficult and developing subject. In the past graphology has suffered from too many sterile measuring techniques just as it may now be treated in too impressionistic a manner for a time.

George E. Reed, M. D.,
Verdun Protestant Hospital,
Montreal.

THE COWRIE SHELL MIAO OF KWEICHOW. By *Margaret Portia Mickey.* (Papers of the Peabody Museum of American Archaeology and Ethnology, Harvard University, Vol. XXXII—No. 1. Cambridge, Mass.: The Museum. 1947.)

This volume is an anthropological study of a tribe of non-Chinese people in the province of Kweichow, China, one of the small pre-Mongol groups who are politically part of China, but who maintain their own biological and cultural entity. These people are the Miao, and the Cowrie Shell Miao, one of the internal groups, are so called because of their use of the cowrie shell as ornaments. Formerly, the cowrie shell was probably used as currency.

Miss Mickey lived with these people and studied their customs and way of life in 1940 and 1942. In her monograph she describes them personally and as a group. Their dialects are a distinct language group, belonging to the Sinitic family of languages. Only a few of the Miao, usually the men, speak Chinese. The Miao themselves have no written language.

The Miao villages are in the mountain valleys, and from Miss Mickey's descriptions the countryside is very beautiful. The people are essentially agricultural, with most of their activities revolving around the rice crop. This type of existence has led to a placid, "gentle" outlook, and the instances of individual behaviour seem to confirm the opinion. They keep to their own customs and manners and marry only among themselves—the man choosing his wife from a neighboring Miao village. His wife must always have a different family name from his own, and since there is seldom more than one name in a village it necessitates going afield for a wife.

Much of the volume is descriptive, especially the economic life—implements used in the rice harvest and planting, division of labour between men, women, and children, preparation of food, inheritance, etc.

Again, purely descriptive and objective are the references to rituals. There seems to be little formal religious activity, although certain rites, such as betrothals, weddings, funerals, etc., have long rituals. Although each village has its priests and shamanesses, these are not held in special regard and are ordinary members of the community except on special occasions.

An important communal activity is the fighting of water buffalo bulls, in the meadow. There is a certain amount of ritual connected with this, such as a colourful procession beforehand, but the event is certainly also a social gathering. Dr. Wu Tzu-lin has contributed a further chapter on details of bull fighting, bull sacrifice, and ceremony entailed.

The photographs included leave something to be desired in clarity and detail, but as they are essential in every study of this sort they have a real value here in portraying house structures, racial types, costumes, and such things that can never be properly pictured from a verbal description.

Miss Mickey's observations are purely objective, and very valuable, particularly to the anthropologist. It is just by such group studies that one is able to study the interactions of one culture upon another, and to determine what aspects of their culture remain, and what aspects are changed in the acculturation process that might be going on in these small Miao villages surrounded by peoples of different stock, customs, and habits. We of the western world are apt to think of acculturation in China as the process of adjustment of Chinese to occidental life: here is an interesting converse, a non-Mongol group becoming sinicized. For anyone interested only in China, this book will be extremely helpful since it describes in detail a western area and people heretofore little known.

MARGARET M. THOMSON, PH. D.
Royal Ontario Museum, Toronto.

PSYCHOBIOLOGY AND PSYCHIATRY. A Textbook of Normal and Abnormal Human Behavior. Second Ed. By *Wendell Muncie.* (St. Louis: C. V. Mosby Co., 1948.)

Psychobiology was never adequately presented by Dr. Meyer. It spread its influence through his pupils. The first edition of this book by one of Meyer's close colleagues appeared in 1939. Now a second edition has come out. The author wisely warns against the tendency of psychiatry to divide up into narrow schools of thought. The reviewer can also strongly endorse Muncie's statement that Adolf Meyer "was a powerful and resourceful therapist who believed in therapy and who uncannily induced in his patients a strong force for personality cohesion and development through his infectious belief that one could always do a better job. This was a delight to all who had the privilege of working with and for him over the years."

The second edition has been edited and brought up to date, but no essential changes are apparent.

S. C.

IN MEMORIAM

CHARLES FREDERICK WILLIAMS, M. D.
1875-1948

Charles Frederick Williams, M. D., died suddenly and unexpectedly at his country home, "Cherry Hill," near Columbia, S. C., June 3, 1948, sixteen years to the day and almost in the same hour and manner in which his wife passed away. It was his wish, many times expressed, that when passing from the mortal to the immortal life he should go without warning, at a time when engaged in one of his favorite forms of recreation, "stalking a wild turkey in the low country of South Carolina or while on a fishing trip." His wish, though not completely but partially so, came true.

A native son, born August 6, 1875, in York County, South Carolina, his early education was in the local schools, and in 1899 his medical degree was conferred upon him by the University of Maryland School of Medicine. His early years in the practice of medicine from 1901 to 1903 were spent in the United States Army, one year of which was spent in the Philippines. Immediately after resigning from the Army and taking a refresher course, he came to Columbia, S. C., to practice general medicine. His ability as a leader in the medical profession was early recognized and in 1908 he became South Carolina's first State Health Officer, which position he held for three years.

His zeal as a public spirited physician led him to greater and nobler achievements. He was requested to take the superintendency of the South Carolina State Hospital, one of the oldest mental hospitals in the United States, and on May 1, 1915, assumed his new duties. He continued in this capacity for thirty years, resigning May 1, 1945, requesting that he be made Director of the Department of Research. He had long recognized that only through research in the field of mental medicine would many of the unsolved problems of alleviating the mentally ill be overcome. He worked diligently to this purpose until his death. Posterity will profit by his efforts in his last years.

Dr. Williams' greatness as a physician and citizen is only partially exemplified by the numerous public recognitions and honors bestowed upon him. He served as president of the Columbia Medical Society; South Carolina Medical Association; Columbia Rotary Club; South Carolina Hospital Association; South Carolina Conference on Social Work; and the Columbia Community Chest. He was president of The American Psychiatric Association, 1934-1935. The University of South Carolina conferred upon him the honorary degree of Doctor of Laws; and he was awarded the South Carolina American Legion plaque for distinguished service. The Algernon Sydney Sullivan award from the University of South Carolina for unselfish service was what he considered his greatest honor.

His greatness is further exemplified by his love for people and his unselfish service to the mentally ill of his native state, rendered at a personal sacrifice. Through his efforts the standards for the care and treatment of the mentally ill were elevated to a position among the best in the nation. As an administrator he could not be surpassed. His philosophy in all of his dealings was that "A thing must not only be right, but it must look right."

The influence of his early Christian training and home life was evidenced by his devotion and activity in the affairs of his church. His child-like faith in his Supreme Master and his exemplary life of service to humanity have brought to him an eternal reward greater than any honor bestowed by his fellowman.

Those who follow him will profit by his teachings, and if the examples set are put into practice far more will be accomplished in the future for the mentally ill.

COYT HAM, M. D.